

TRANSCRIPT OF PROCEEDINGS

INS 9 Meeting

Madison, Wisconsin
April 26, 2006

Reported by: Rebecca Farris

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I N D E X

E X H I B I T S

| No. | Description | Identified |
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(There were no exhibits marked
for identification)

(Original transcript filed with Ms. Mallow)

1 TRANSCRIPT OF PROCEEDINGS, taken at the
2 State of Wisconsin Office of the Commissioner of
3 Insurance, 125 South Webster Street, Madison,
4 Wisconsin, before Rebecca Farris, a Notary Public in
5 and for the State of Wisconsin, on the 26th day of
6 April 2006, commencing at 2:11 in the afternoon.

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A P P E A R A N C E S

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11 COMMISSIONER OF INSURANCE PANEL

12 Jorge Gomez
13 Eileen Mallow
14 Fred Nepple
15 Sue Ezalarab

16

Also present: Pat Osborne, Kathryn Ambelang,
17 Dan Schwartz, Josh Watson,
18 J.P. Wieske, Robert Phillips,
19 Jeremy Levin, Vaughn Vance,
20 Marilyn Windschiegel, Kristine Thurston
21 Toppe, Moira Fitzgerald, Laura Leitch,
22 Joan Curran, Karen Geiger,
23 Phil Dougherty, Bill Toman, Mary Michal,
24 Dan Hayes, Titus Muzi, Kathy Stephenson,
25 Coreen Dicus-Johnson, Julie Swiderski,
 Allan Patek, Rose Smyrski,
 Michelle Mettner

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1 THE COURT: Good afternoon. This
2 is the bad penny situation, isn't it, we
3 can't get away from each other. Why don't we
4 go ahead and get started.

5 I'm Jorge Gomez, Commissioner of
6 Insurance. We actually have a record here
7 being kept, and what I'd like to do as we
8 sort of look at the statement of scopes for
9 our proposed rule revisions of what was
10 presented previously to JCRAR, INS 9 --
11 before we start all that, I'd like to get all
12 the names of the folks at the table, so we
13 have a record of that. And then I think --
14 and there's a sign-up sheet going around.
15 And what will also be going around in just a
16 few minutes are copies of the suspended rules
17 on basically -- the main issues are really
18 going to be the emergency room issue and we
19 won't talk much about that today, but the
20 ancillary service disclosure question, which
21 we'll get copies of today and we'll spend
22 some time discussing. We've got some written
23 comments on that, and we'll talk about that.
24 Let's talk a little bit about the plans for
25 approaching -- working on this stuff for the

1 next couple weeks or the next couple months,
2 and anything else you want to talk about, I
3 guess. So why don't we start at my right.

4 MR. NEPPLE: Fred Nepple, General
5 Counsel.

6 MS. METTNER: Michelle Mettner for
7 Children's Hospital of Wisconsin.

8 MR. OSBORNE: Pat Osborne with WPS.

9 MS. AMBELANG: Kathryn Ambelang
10 with WPS.

11 MR. SCHWARTZER: Dan Schwartzer
12 from Wisconsin PPO Association.

13 MR. WATSON: Josh Watson, United
14 Health Care.

15 MR. WIESKE: J.P. Wieske, the
16 Council for Affordable Healthcare.

17 MR. GOMEZ: Don't you have anything
18 else to do?

19 MR. WIESKE: I've got lots to do.

20 MR. GOMEZ: Council for Affordable
21 Healthcare Insurance.

22 MR. WIESKE: Absolutely.

23 MR. GOMEZ: You're still with those
24 guys?

25 MR. WIESKE: Huh?

1 MR. GOMEZ: Okay. Never mind.

2 MR. PHILLIPS: Robert Phillips for
3 Marshfield Clinic.

4 MR. LEVIN: Jeremy Levin, Wisconsin
5 Medical Society.

6 MR. VANCE: Vaughn Vance, WEA
7 Trust.

8 MS. WINDSCHIEGL: Marilyn
9 Windschieg1, WEA Trust.

10 MS. THURSTON TOPPE: Kristine
11 Thurston Toppe, the National Committee for
12 Quality Assurance.

13 MS. FITZGERALD: Moira Fitzgerald,
14 Aurora Health Care.

15 MS. LEITCH: Laura Leitch,
16 Wisconsin Hospital Association.

17 MS. CURRAN: Joan Curran,
18 representing Gundersen Lutheran Medical
19 Center and Gundersen Lutheran Health Plan.

20 MR. GOMEZ: Nice to see you again.

21 MS. CURRAN: Thank you.

22 MS. GEIGER: Karen Geiger,
23 BlueCross/BlueShield.

24 MR. GOMEZ: Who left something in
25 my bags in my yard recently. Thank you very

1 much. Those are cute dogs of yours.

2 MR. MUZI: Titus Muzi,
3 BlueCross/BlueShield.

4 MS. STEPHENSON: Kathy Stephenson,
5 Network Health Plan/Affinity.

6 MS. DICUS-JOHNSON: Coreen
7 Dicus-Johnson, Wheaton Franciscan Healthcare
8 of Covenant and All Saints.

9 MS. SWIDERSKI: Julie Swiderski,
10 Wheaton Franciscan Healthcare.

11 MR. PATEK: Allan Patek, Humana.

12 MR. GOMEZ: Mr. Patek, how are you?

13 MR. PATEK: Good.

14 MS. EZALARAB: Sue Ezalarab, OCI.

15 MS. MALLOW: I'm Eileen Mallow,
16 OCI. Should we do the back row too?

17 MR. GOMEZ: Oh, sure.

18 MR. DOUGHERTY: Phil Dougherty,
19 Wisconsin Association of Health Plan.

20 MR. TOMAN: Bill Toman, Quarles &
21 Brady law firm.

22 MS. MICHAL: Mary Michal, Reinhart
23 Boerner law firm.

24 MR. GOMEZ: Wow, the law firms are
25 represented today too.

1 MR. HAYES: Dan Hayes, Blumenfield
2 & Associates. We work with the Wisconsin
3 Society of Radiologists.

4 MR. GOMEZ: Well, welcome. If you
5 notice on my desk, this is a much smaller
6 stack of documents than we had the last time
7 we had before this rule went -- ran the
8 gauntlet.

9 There are really two -- there's a letter
10 dated April 11th that went out that just
11 pretty much discussed what we're going to try
12 to talk about today, relative to the
13 ancillary service question. And I'd like to
14 talk about that at length. We have a couple
15 hours to do that.

16 The emergency room issue is still out
17 there as well, and I think what I'd like to
18 do before we just jump into everything -- and
19 I understand it's slightly out of order, but
20 it shouldn't take too much time to go through
21 it -- but I'd just like to get some very
22 brief information on the emergency room
23 discussion that we had before, and I think
24 once Jim gets here with copies of both rules
25 that were proposed, we can just kind of usher

1 through that. Because I think fundamentally
2 -- and just really because of directions from
3 JCRAR I think that rule can get -- that part
4 of the rule can get wrapped up pretty
5 quickly. I don't see us spending a lot of
6 time on that, necessarily, unless people want
7 to. I thought it was pretty close to
8 unanimous consensus last time. But I think
9 fundamentally we're going to be looking at
10 potentially modifying our rule to the extent
11 that it may be consistent with what was
12 proposed by, I believe it was Senator Kapanke
13 and Representative Nischke, and see where we
14 can go from there very quickly.

15 If you could just spare us a few minutes
16 to get those copies up, or in the meantime,
17 assuming that doesn't take forever, we can
18 sort of delve into the question related to
19 the disclosures that we're talking about for
20 ancillary services when people seek elective
21 treatment.

22 I think just sort of a foray into that
23 discussion, the Agency's view, given the
24 kinds of complaints that we were getting, is
25 that the principal really is that we're

1 trying to find some way so for patients to be
2 informed prior to services being rendered of,
3 you know, that -- well, that patient has the
4 opportunity to make an evaluation of what
5 potential costs they are facing by going to a
6 particular provider who may be in or
7 out-of-network or to be in system that may
8 have some providers in-network and some
9 providers out-of-network. So I do think once
10 we get the language here, we'll have a chance
11 to talk about that some more. Any hint?

12 MS. MALLOW: Few minutes yet.

13 MR. GOMEZ: Few minutes yet. Okay.
14 We'll take a few minute break because I want
15 you to work off that document a little bit.

16 We have some comments from the Wisconsin
17 Medical Society, Marshfield Clinic, and
18 Gundersen Lutheran, and I'm sure there's
19 others who want to talk about that as they
20 did before. Try to be unique about it, okay,
21 try to come up with something different.

22 MR. WIESKE: Pig Latin, maybe.

23 MR. GOMEZ: You did that the last
24 time.

25 (Recess taken)

1 MR. GOMEZ: Sorry about the delay
2 folks, but you should all have a copy of the
3 language we were talking about. What you
4 have before you is a document that has a
5 variety of motions that are required of
6 JCRAR. Motion one has the issue that we're
7 going to talk about at length today, dealing
8 with disclosures; and motion two deals with
9 the emergency room service issue. And I
10 guess what I'd like to do is just taking
11 things briefly out of order, and we'll jump
12 to this even in more detail, but relative to
13 the question of the emergency room services,
14 and I know most of you don't have documents
15 relative to that date, but I think most of
16 you didn't have issues with that before.

17 Also attached to this is our proposed
18 language which is on page 24 of the
19 attachments and SB 617, which deals with the
20 bill or the legislation that was recently
21 vetoed on for regulation, but relative to
22 this issue is also the language that deals
23 with the emergency room question.

24 And, I guess, Dan, just because I know
25 that you had a lot to do with this piece of

1 the bill, what, just so we're clear, because
2 I think this is something that can get
3 resolved more quickly than we otherwise
4 thought, what is the main issue with the OCI
5 proposed language?

6 MR. SCHWARTZER: The only issue
7 that we had remaining with that particular
8 provision was adding language pertaining to
9 stabilization, so when is the patient stable
10 enough to begin paying out-of-network
11 benefits and/or having the patient moved to
12 an in-network facility. And I know that you
13 had referenced, I think, the same exact
14 Federal Social Security Act verbally in one
15 of our previous meetings --

16 MR. GOMEZ: Yeah.

17 MR. SCHWARTZER: -- and we just
18 felt that it should be included in the reg.

19 MR. GOMEZ: And when we talk about
20 stabilization, does that -- as we kind of
21 deal with the nuances of that question, what
22 does stabilizing the patient really mean,
23 does that include sort of evaluation of the
24 patient as well as treatment of the patient,
25 and I guess that stabilization then means

1 what?

2 MR. SCHWARTZER: It means a
3 definitive point in time in which the
4 patient, according to the physician, is
5 stable enough to move from one facility to
6 another facility. And in our opinion, from
7 our perspective, that's an important piece
8 because then it can establish when
9 out-of-network benefits can begin and/or when
10 the patient would move into an in-network
11 facility.

12 MR. GOMEZ: I mean, currently the
13 practice would be, it would seem, that any
14 movement of a patient would be driven by the
15 doctor's evaluation and determination that
16 it's safe to move the patient. Is your
17 concern that a hospital that is
18 out-of-network would hold onto the patient
19 indefinitely?

20 MR. SCHWARTZER: No.

21 MR. GOMEZ: Okay.

22 MR. SCHWARTZER: Our concern would
23 be that the patient would remain in the
24 out-of-network facility because that's the
25 facility they're currently in and they don't

1 want to move, and the in-network benefits
2 would have to continue. And what we wanted,
3 from our perspective, the current -- the
4 proposed regulation had no cutoff, so as long
5 as that patient remained in that facility,
6 you were paying in-network benefits. And our
7 point was depending on what the condition
8 could be, you could be talking about a very
9 long, extended period of hospitalization,
10 where it would be unnecessary to continue the
11 in-network benefits for the purposes of why
12 we are even addressing this emergency care
13 situation. Because when you're in an
14 emergency, you can't choose your in-network
15 facility -- you can't choose the facility;
16 you're just taken there. We don't disagree
17 with that.

18 MR. GOMEZ: All right. The rule is
19 driven by the notion of the incapacity to
20 really make an elective choice based on a
21 true emergency as we define it. And then the
22 question is -- all right. Trying to do the
23 metaphysics of when somebody can get moved,
24 and I don't know how that gets dealt with. I
25 mean, obviously, doctors don't want to move

1 patients prematurely. Just one last thought
2 on this. So the stabilization means that the
3 patient can be moved safely after they've
4 been quote/unquote stabilized to a facility
5 that is in-network.

6 Just some hypotheticals, and we'll
7 get -- and I know you have a point. So let's
8 just say you have a burn patient, kid,
9 someplace in northern Wisconsin, on vacation,
10 gets too close to the grill, severe burns,
11 right, gets admitted to the hospital. It's
12 an out-of-network facility. Assuming that
13 the true burn hospital is -- or one that can
14 competently deal with severe burns is
15 somewhere in Green Bay, or let's say
16 Milwaukee, let's say, the Children Hospital
17 or something. You're saying if that child
18 gets stabilized, you know, within, let's
19 say -- usually burns is probably something
20 different -- but let's just use that as an
21 example. He's not going to be traumatized,
22 he's not going to lose his life, that child
23 can be transported by ambulance safely to
24 Milwaukee. That's the point at which the
25 inpatient -- or the in-network reimbursement

1 should be cut off, after that patient is
2 capable of being transferred.

3 MR. SCHWARTZER: If the patient is
4 capable of being transferred and determines
5 that they are more than willing to be
6 transferred to an in-network facility, so be
7 it. But if they're not willing and they
8 don't want to be transferred to an in-network
9 facility but they are stable according to the
10 language, then the carrier or the plan can
11 begin paying out-of-network benefits, because
12 it becomes an option again versus a
13 circumstance --

14 MR. GOMEZ: Let me ask a question
15 before you jump in. If it's consistent with
16 the doctor's recommendation that the patient
17 can be transferred, I don't think most of us
18 have an issue. But if it's consistent with
19 the recommendation by that doctor that the
20 patient shouldn't be transferred, where do
21 you see the issue falling? I mean, we may
22 have some difference of opinion on this, and
23 I'm just kind of wondering where that falls
24 in this analysis. I mean, most people get
25 kicked out of the hospital these days. Open

1 heart surgery, people are out in four and a
2 half days on average.

3 MR. SCHWARTZER: I think that's one
4 of the reasons we're using the existing Act
5 in the Social Security Act because they had
6 defined, and it was not dissimilar to the, I
7 think, it was the Nebraska language that we
8 had originally offered as a suggestion, in
9 which they defined what stabilization was.

10 MR. NEPPLE: The proposed rule uses
11 language covering for emergency medical
12 services which obviously conveys that the
13 services that are subject to in-panel
14 requirement are emergency services, which I
15 think was assumed to address your concern
16 that the patient might stay and continue to
17 receive services on an in-panel basis after
18 the emergency is over. What I'm trying to
19 understand as a potential drafter here is
20 what the distinction is between services
21 until stabilized versus covered emergency
22 medical services. What is the distinction
23 there and give an example? And using the
24 burn again, you have a second-degree burn,
25 the child comes into the emergency room,

1 well, the kid may be screaming, but they can
2 always be put in an ambulance and moved
3 across town. When the MD gives you something
4 for pain, that probably isn't emergency
5 medical services and it may not be necessary
6 to stabilize. Is that the distinction you're
7 trying to make?

8 MR. SCHWARTZER: No. We're trying
9 to make the distinction of -- an example of
10 my son who broke his leg up in -- the same
11 thing, vacation. The emergency services he
12 was provided was traction. But once he was
13 stabilized so that they could put him in an
14 ambulance in traction to move to a different
15 facility --

16 MR. NEPPLE: When your son received
17 something for pain as well and perhaps
18 received an x-ray which wasn't necessary for
19 putting him in traction perhaps, would you
20 view that as still appropriately covered on
21 an inpatient basis?

22 MR. SCHWARTZER: Yes. All the
23 services provided at that particular
24 out-of-network facility if it is, that are --
25 can cover the emergency service, should

1 continue to be paid as in-network, and once
2 the patient is stable, services from that
3 point forward should be looked at as either
4 out-of-network or transferred to an
5 in-network facility.

6 MR. GOMEZ: So diagnostic services
7 that lend themselves to stabilize that
8 patient in your mind would be covered as if
9 it were in-panel?

10 MR. SCHWARTZER: Uh-huh.

11 MR. GOMEZ: Okay.

12 MS. CURRAN: I have two questions.
13 One is, is that the patient is stable now,
14 you transfer using an ambulance, and what if
15 on of your benefits are that that would not
16 be considered a covered benefit because it
17 doesn't meet the criteria for transfer.
18 Would you continue to pay for that, or is the
19 patient going to get a bill for that?

20 And then the second question I have is
21 what about the case where they come into the
22 emergency room and now they get transferred
23 to surgery? Are you going to pay for the
24 surgery even though that might -- the
25 diagnosis of that will be different and not

1 linked to the emergency?

2 MR. SCHWARTZER: I'll defer to some
3 of the carriers in the room that are members,
4 but I would suspect that they would go -- or
5 that they would follow what they're currently
6 practicing as many of them do now, in terms
7 of moving the patient from one facility to
8 the next. They pay for the emergency as
9 in-network even though it was an
10 out-of-network facility. And I think they
11 make the determination based on -- even if
12 the ambulance isn't covered as it were
13 transferring to the in-network facility,
14 where we have the discount and where that's
15 going to be costly. What this does is just
16 simply establish a baseline that says, the
17 carrier can do that. Now we've got a
18 regulation that says they have to, now that
19 we've set a baseline that the carrier can
20 move them or begin paying out-of-network
21 benefits. But again I would defer current
22 practice to the carrier move.

23 MR. WIESKE: J.P. Wieske with CAHI.
24 I think the intent here, as I understand it,
25 has little to do with, you know, something on

1 a fairly acute basis. We're talking about
 2 something that's going to tend to go long
 3 term or more likely than a few days. And so
 4 when you're looking for an extended inpatient
 5 stay, I think what we're looking for is you
 6 don't want to have 30 days out where you have
 7 a blank check. You want to have something
 8 that's available to negotiate movement of the
 9 patient to another facility that is less
 10 costly to you, provided of course -- I think
 11 the burn example would be a little bit
 12 different because there would be specialized
 13 care there. But you know, provided that the
 14 patient is stable, provided the patient can
 15 receive similar care in another facility
 16 that's a little cost in-network, be it across
 17 town, be it someplace else, I think the point
 18 is is that, you know -- an I think as a
 19 matter of practice, I think it happens
 20 rarely. It doesn't happen very often. But
 21 there are a few cases where there are
 22 extended stays that are longer periods of
 23 time where you want them to transfer to
 24 another facility.

25 MS. LEITCH: Laura Leitch,

1 Wisconsin Hospital Association. We have to
 2 remember that providers have an obligation
 3 under EMTALA where they can't transfer
 4 patients in certain circumstances or they're
 5 required to transfer the patient to a
 6 specialized provider. The burn example is
 7 perfect because Wisconsin only has few burn
 8 units. So the provider is required to
 9 transfer that patient to a specific hospital
 10 or they, you know, they have Medicare
 11 regulation problems. So it seems to me that
 12 we need to make sure that the patient isn't
 13 going to get stuck with the tab when the
 14 provider is following what they have to do
 15 under the Medicare regulations and that this
 16 rule is consistent with those regulations.

17 MR. GOMEZ: I think that was some
 18 of the initial tension when we were talking
 19 about this and trying to figure out whether
 20 the --

21 MS. CURRAN: That's exactly my
 22 point. Because what will happen is you're
 23 trying to protect their out-of-pocket cost,
 24 and if they don't have benefits for the
 25 transport or for the surgery because of how

1 the claim comes in, they'll get caught and
2 the EMTALA is a whole, you know --

3 MR. SCHWARTZER: Does sub C
4 conflict with that? It would be page 8, the
5 very last sheet, page 8, line 12.

6 MS. LEITCH: It depends on how that
7 would be interpreted because it may not be
8 stabilized at that particular provider. If
9 it's stabilized in the general sense, which
10 might include a transfer to a specialized
11 provider, then that might work out. But it
12 needs to recognize that stabilize might not
13 mean at that particular location, that it
14 could involve a transfer to stabilize.

15 MR. GOMEZ: What was the acronym
16 that you referred to?

17 MS. LEITCH: EMTALA, E-M-T-A-L-A.

18 MS. DICUS-JOHNSON: This is Coreen
19 Dicus-Johnson, Wheaton Franciscan Healthcare.
20 How do you see this language applying to a
21 situation where a person is in an in-network
22 hospital, has an elective procedure, but an
23 emergency situation arises where they need to
24 bring in a specialist that may or may not be
25 contracted? I'm thinking of neonatal or

1 something along those lines where -- outside
2 of the hospital-based doctors, is the other
3 issue -- how does this language address that
4 issue?

5 MR. SCHWARTZER: Well, my
6 understanding of your original -- OCI
7 original language is that specialists would
8 have to be covered, correct me if I'm wrong,
9 would have to be covered under the current
10 regulation as proposed by the OCI. What
11 we're asking for, in terms of the
12 stabilization language, would not affect that
13 particular example.

14 MS. DICUS-JOHNSON: Well, I didn't
15 see anything in the proposed language that --
16 we talk about emergency medical services, and
17 the way that the language is drafted, at
18 least the way I read it, was that it implies
19 that there was a person that was going
20 physically to a particular site. I'm talking
21 about a situation where an emergency arises
22 that they're at the right hospital, but now
23 they need a neonatologist to take care of a
24 situation and that particular specialist is
25 not covered and it's an emergency situation.

1 I'm not clear that this language --

2 MR. PATEK: Are you describing a
3 situation now where the person on call would
4 take the case?

5 MS. DICUS-JOHNSON: Right. It
6 could be on call or you know there are some
7 hospitals that require these physicians to be
8 in the hospital when a cesarean is being
9 performed. Those are the types of
10 situations, that there's an emergency that
11 requires some specialized services.

12 MR. NEPPLE: I don't know if we
13 specifically looked at this, but I would be
14 inclined to agree with Dan, that the proposed
15 rule that says that it's covered.

16 MS. DICUS-JOHNSON: But it's
17 covered?

18 MR. NEPPLE: It refers to the
19 definition of emergency medical condition
20 under the statutes, which I think would
21 encompass that situation.

22 MS. EZALARAB: I agree.

23 MR. GOMEZ: There seems to be some
24 head nodding.

25 MR. WIESKE: You know, I think

1 based on this, I mean, you know we're talking
2 about surgeries -- I don't want to go too far
3 afield here. You know, certainly in some
4 cases there may be exceptions, but I think in
5 most case when, you know, a surgery kind of
6 situation arises in, you know, an emergency,
7 I think in most cases somebody breaks their
8 leg or something along those lines, I would
9 suspect that, you know, the surgery, despite
10 the fact you would stabilized, would be
11 considered part and parcel of that emergency.
12 I would be surprised if it wasn't. I think
13 that would be a fairly normal situation.

14 I think there may be certain exceptions
15 to that obviously. Something that, you know,
16 where you're going to eventually need
17 surgery, you don't need it today, you don't
18 need it tomorrow, but eventually you'll need
19 surgery, there might be some exceptions to
20 that, you know, as a general rule.

21 But I think for the most part when we're
22 looking at this language and talking about
23 stabilization, I think at least from our view
24 what I think we're expecting is somebody who
25 is expected to be in the hospital 30 days, at

1 some point they're stabilized, and you
2 know -- or 60 days or something, there's
3 going to be a long-term sort of situation in
4 the hospital which is rare, that at some
5 point they can be transferred to another
6 hospital safely. And I think that's what
7 we're talking about, just not a blank check
8 that they would stay necessarily in that same
9 out-of-network hospital forever. And again,
10 I think it's going to be a longer-term
11 situation rather than shorter-term.

12 And I think this goes on as current
13 practice today. I don't think this is
14 anything new. This is, you know -- is
15 typically negotiated with the insurance
16 company and the providers. They talk about
17 it. They make decisions as to what makes
18 sense for the patient, for coverage, and I
19 think this just expands, you know, expands
20 the patients' rights here.

21 MR. GOMEZ: Okay.

22 MS. CURRAN: I have a question
23 outside of stabilization, and that's payment.
24 From the motion it looks like the insurance
25 company is required to pay as if in-network.

1 However, it looks in the last couple of lines
2 as if that payment is at the nonparticipating
3 provider rate, less coinsurance, deductible,
4 et cetera. And so can I assume as a
5 provider, since I'm nonparticipating, that I
6 would be able to balance bill that member?
7 So I wouldn't be held harmless.

8 MR. SCHWARTZER: Well, the
9 contract -- as far as my interpretation goes.

10 MR. GOMEZ: I think the answer is
11 yes.

12 MS. CURRAN: In thinking about
13 protecting the consumer then, they would have
14 an out-of-pocket cost.

15 MR. GOMEZ: They would have had one
16 anyway. Right?

17 MS. MALLOW: Right.

18 MS. LEITCH: So this would be tied
19 to the federal antidumping rules then? Is
20 that --

21 MR. GOMEZ: Yeah, I mean, I think
22 that was the effort. I think the allusion
23 in -- what is the number? Page 8, SB 617, is
24 to address that. And it could very well
25 maybe be more specifically spelled out, but

1 obviously we need to have a rule that's going
2 to be consistent with that and I think that's
3 where some of the tension was as to whether
4 or not the notion of stabilization, and maybe
5 this language is actually pulled out of that,
6 is this consistent enough with that rule to
7 be spelled out clearly enough so that you
8 understand what that means. But there were
9 questions about it.

10 MR. NEPPLE: It might be helpful if
11 you could provide some language in addressing
12 that. I heard you describe a situation,
13 which I'm not sure how the proposal language
14 in SB 617 would apply. And I heard you
15 describing a patient who is a burn patient
16 who is stabilized but requires the transport
17 then to a burn center.

18 MS. LEITCH: No, they wouldn't be.
19 They're not stabilized. Is that what you
20 said?

21 MS. CURRAN: Yeah.

22 MR. NEPPLE: So your scenario is
23 they were not stabilized?

24 MS. LEITCH: Right. Because
25 generally the federal rule is that the

1 hospital has an obligation to treat until
2 they are stabilized except in those
3 situations where they need to be transferred.

4 MR. GOMEZ: Right.

5 MR. NEPPLE: Okay.

6 MR. GOMEZ: Any more thoughts on
7 this? I guess my proposal would be that --
8 we'll get some dates set up, but get us some
9 language, and we'll incorporate that and
10 circulate it among all the parties here
11 today, and revisit -- I don't think we're
12 going to spend a lot of time on this. I
13 don't think we're too far apart on this. And
14 so we'll circulate something and just propose
15 whatever thoughts you have, and we'll have --
16 we'll have it drafted up, circulate it, we'll
17 get comments, we'll come back and talk about
18 it some more, and then see where we end up
19 after another meeting on this specific issue.

20 Okay. On the meat-and-potatoes issue of
21 the day, we're looking at the question
22 relative to the disclosures of information
23 for elective services, you know, whether or
24 not the patient can get access to who the
25 potential providers will be, in-network

1 versus out-of-network.

2 We have comments that were submitted --
3 I want to make sure these comments are
4 available to everyone -- from Wisconsin
5 Medical Society, Marshfield Clinic, and
6 Gundersen Lutheran. Let's just go in the
7 line of ascendancy in which I received
8 comments, and then maybe a summary of what
9 each organization thinks is the issue. I'll
10 try to restate what our Agency's concern is.
11 I know I've met with some of your entities at
12 some different stages in the last several
13 months to talk about our perceptions of why
14 this should be something we can work on and
15 resolve.

16 And so with that thought, if the Medical
17 Society just wants to sort of generally tell
18 us what their position is.

19 MR. LEVIN: Jeremy Levin from the
20 Medical Society. Generally, we see it sort
21 of adding a burden to sometimes an already
22 overburdened system, that any time taking on
23 an administrative task such as this, would
24 probably take away from direct patient care.
25 And sort of not seeing how also if somehow

1 care changes, the need of the patient
2 changes, what happens then to -- do they have
3 to provide a new list of providers who are
4 in- and out-of-network and who they might be
5 seen by. I mean, there's some of those
6 worries. And I guess we brought up, and
7 everyone will see when they get it, just some
8 of the other initiatives that are going on to
9 add to the transparency of that. The Medical
10 Society has been part of that and may offer
11 different avenues than this requirement or
12 disclosure.

13 MR. GOMEZ: Let me ask you this, I
14 mean, just as a practical matter. I spoke
15 with a chiropractor yesterday, not for my own
16 purposes. I don't think I'd trust a
17 chiropractor right now with some of our
18 positions on things. My last adjustment.
19 This guy gets a patient who -- I don't
20 know -- has all sorts of back problems
21 apparently, and even though he may have a
22 contract with, you know, with the health
23 insurer, he's got a variety of folks in his
24 operation who do not. And I don't know why
25 that is, and I didn't ask him the details as

1 to why not. But if I go -- and let's just
2 say he has a massage therapist, and he has a
3 whole other host of ancillary service
4 providers, including a radiologist --
5 typically they do their own x-rays, but some
6 of them actually have a separate radiology
7 group that takes the x-rays. In that small
8 practice environment, you know, what is the
9 administrative burden that you perceive as
10 being onerous? I go to -- you know, the
11 patient goes to him. What am I expected to
12 pay? This is my plan. He knows that some of
13 these folks are not in his plan, if it's
14 Humana, BlueCross, whatever, and you know,
15 that patient doesn't know that they're going
16 to get hit with out-of-network services and
17 be on the hook for that amount. You know,
18 when you're dealing with the question of what
19 pressures are on doctors to have their
20 billing person explain who's in-plan and
21 who's not in-plan, I'd like to know what the
22 burden is at that stage. Because as I
23 discussed this with him, he made one phone
24 call to one insurer to find out what the
25 deductible was and whether anybody else was

1 in that network, and they even made some
2 referrals. I don't know how long it took
3 that billing service -- or his biller to do
4 that. But that's just a simple one, okay,
5 but that's sort of typical of some of the
6 issues we get in the Agency with the
7 complaints that we get. That somebody goes
8 to what they think is an in-plan provider
9 with in-plan ancillary services behind the
10 doors, you know, and then they discover the
11 lab is out-of-network, you know, radiologist
12 is out-of-network, and we haven't even talked
13 about more serious issues, hospitalization,
14 surgeries, and all that kind of stuff. But
15 at that level what's the big deal?

16 MR. LEVIN: Well, I'm glad there's
17 other groups here. Because I think they can
18 explain in greater detail than I can. I
19 think what you might see in problems is
20 sometimes just a delay too. Yeah, maybe a
21 small group can do something very quickly,
22 you know, if a larger group -- and even from
23 personal medical attention I've sought, I'll
24 have an x-ray read out by the attending
25 physician, but let's say, I mean, then it

1 sometimes gets re-read by a specialist or a
2 radiologist to make sure something isn't
3 missed. I think it would be tough to add in,
4 well, who's on call that day or what if
5 something shuts down, part of this they'd
6 have to -- I don't know -- subcontract work.
7 Again, I would rather hear some of the groups
8 talk because I think they can go into greater
9 detail. But I think you'll never really be
10 able to fully provide, and it will be just a
11 nightmare on everyone's minds. And probably
12 for a patient to try and deal and understand
13 that is probably complicated too when all
14 they want is more time with the physician and
15 more direct care.

16 MR. GOMEZ: Well, I'll tell you
17 what the patients want, they want the
18 treatment. Then what the patient also wants
19 is something that they anticipated in their
20 health plan. Because when we get other
21 complaints that say, basically, wait a
22 second, this is out-of-network? You know, my
23 deductible is no longer 500 bucks, it's
24 1,000. My out-of-pocket is going to be X
25 instead of Y. And I think we have to be fair

1 because in the context of the way a lot of
2 this -- a lot of the product is evolving in
3 the marketplace, and your constituents will
4 know more than anyone else, you have
5 consumer-driven healthcare products, larger
6 deductibles, a lot of cost transference
7 that's going to them, and you know, probably
8 a lot of unanticipated charges that are
9 either paid by them or else written off as
10 bad debt by the provider groups. There's a
11 lot of stuff that goes on, I know, but so
12 when you're looking at the culture -- I won't
13 just call it the culture of healthcare
14 insurance -- but really the economics of it
15 are driving it into a direction where the
16 notion of transparency is becoming more and
17 more important because more and more -- the
18 people are, you know, individuals are
19 retaining much more of the upfront costs and
20 obligations through premium charges and also
21 the deductibles and copays, et cetera. It
22 makes a big difference for them to know at
23 the point of service whether or not their
24 service is going to be in-network or
25 out-of-network. There's been a lot of

1 variability, and we had a lot of discussion
2 before on, you know, what product design
3 should look like, the market demands. So now
4 the other side of the market demand is, in
5 our view -- clearly in my view, and I think
6 it's shared by my colleagues -- is that
7 patients should know what the money is going
8 to look like, what the economic consequences
9 are going to look like, and how do we best
10 enhance their perception of what the bill is
11 going to look like at the point of service
12 before they get treated.

13 MS. DICUS-JOHNSON: Can I make a
14 comment with regard to the example that you
15 made? I think that what you've
16 articulated the first question I would have
17 is how does that particular office hold
18 themselves out to the public, in terms of
19 whether or not they were contracted? And
20 what I mean by that is when Sally goes in to
21 look at the directory to see if this
22 particular chiropractor is a part of the
23 network, is she looking by the provider or is
24 she looking by the clinic or the office. So
25 the first question I would have is how are

1 they holding themselves out in terms of their
2 contract?

3 So it gets back to -- you know, our
4 position as healthcare providers is that, we
5 mentioned this earlier, the party with the
6 best information needs to provide that
7 information. And who holds the information?
8 For example, the example that you just
9 provided. If the HMO or the insurance
10 carrier listed the clinic, the place of
11 business, as being a contracted provider,
12 there's an expectation by that patient that
13 whatever services that were rendered in that
14 facility would be covered, because of how it
15 was articulated in the directory or online or
16 with who they spoke. If the information
17 that's provided by the insurance carrier is
18 by provider, Dr. Smith, then there should be
19 a different expectation about other people in
20 that setting, whether or not maybe they're
21 all independent contractors that are sharing
22 office space, and Dr. Jones who's in that
23 particular office is not contracted with
24 whoever the insurer is. So that would be the
25 first question I have.

1 And to answer the question more on terms
2 of the administrative requirements, I'd like
3 to go to a situation that as a hospital
4 provider that we would have to deal with in
5 terms of the administrative requirements that
6 the rule as written would require us to
7 comply with. We have, at our hospital,
8 contracts with our hospital-based doctors, we
9 have anesthesiologists, ER doctors,
10 pathologists, and radiologists. They are not
11 our employees. They are independent
12 contractors that we basically provide a place
13 for them to do their work. We have no way of
14 knowing, because of their independence, who
15 they have contracts with on a given day. We
16 had a situation recently where a large payer,
17 who has national requirements, that are
18 coming -- they're coming in to try to lower
19 the reimbursement that a particular
20 hospital-based doctor group was receiving
21 previously, took the position that they
22 wanted to drastically reduce their pay by
23 50 percent. This is not information that a
24 hospital necessarily knows, because again
25 these are two other parties that are outside

1 of the scope of our relationship. So if we
2 were to take a practical reading of the
3 current rule, and require our physicians, an
4 OB-GYN, or whoever who would be providing
5 surgical services to a particular patient in
6 one of our hospitals, they would have to get
7 an updated -- or somebody on our team would
8 have to get an updated understanding with
9 each one of the hospital-based doctors as to
10 where they were on a particular day with
11 regard to their contract. And for us to be
12 able to comply with that type of requirement
13 is just too onerous. We don't have that
14 information. That is information that is
15 housed with the insurance carriers, and we
16 think they are in the best position to
17 provide that.

18 MR. GOMEZ: Okay. Well, there's
19 some tacit agreement that the patient is the
20 one who doesn't have to provide the
21 information we're assuming at this stage; am
22 I right?

23 MS. DICUS-JOHNSON: I'm sorry?

24 MR. GOMEZ: I mean, I'm just
25 trying to narrow it down. Because your

1 statement was, who's in the best position to
2 know, and we're not expecting the patient to
3 always be in the best position to know.

4 MS. DICUS-JOHNSON: I would agree
5 because the patient isn't always in the best
6 position to know who holds contracts with
7 their respective insurance carrier.

8 MR. GOMEZ: Okay. But so we're
9 dealing also with the question of
10 expectations and then what are the failed
11 expectations as we see it. So I open up my
12 directory and it says this hospital -- or
13 yeah, this hospital is in my network. I can
14 get treated there, all right? Now the
15 expectation is -- is it a broad expectation
16 or is it narrow expectation -- do I expect if
17 my wife is going to have a baby that the OB
18 doctor is going to be in-network and that any
19 services associated with the delivery,
20 whether it's a simple one, an easy one versus
21 a complicated situation, is it my expectation
22 as a patient that that's going to get
23 covered? Is that a reasonable expectation?
24 My answer to that is it is. That's why we're
25 having this discussion.

1 MS. DICUS-JOHNSON: I agree.

2 MR. GOMEZ: But there's some
3 disagreement that that should not be the
4 expectation.

5 MS. DICUS-JOHNSON: Well, I can
6 only speak for our organization. I can tell
7 you that I think there is a reasonable
8 expectation when you go into an in-network.
9 The question is is what additional
10 information and who should provide it. My
11 issue is the way the rule is drafted right
12 now, our positions are -- as a participating
13 provider, we would be in the position of
14 supplying that information to our patients,
15 and I'm saying we can't comply with that. We
16 will not be able to meet that expectation.

17 MR. GOMEZ: Just one other question
18 on that issue. Again, looking at the
19 referral or the directory that says this is
20 the hospital versus the directory that says
21 this is the doctor. Again, how is it that --
22 it would seem to me in any -- in either
23 instance the expectation is by the patient
24 that I'm going to be treated. Now if the
25 expectation is that the doctor is in X

1 hospital and the patient goes to that
2 hospital.

3 MS. DICUS-JOHNSON: Well, I agree.
4 Hospital -- you know, there's a listing of
5 certain hospital-based doctors. I think what
6 would accomplish that is is that the
7 directory would be required to list the types
8 of doctors that aren't -- because that's the
9 other problem, they're not listed typically,
10 at least in my experience, they aren't listed
11 anyplace else in the directory to link it to
12 the hospital. So if you're a patient trying
13 to follow the rules, now this may have
14 changed, but I don't believe this is the
15 case, if you look and find hospital,
16 Community Memorial, and you look at the types
17 of -- it's in-network, but what I'm
18 suggesting is that an additional requirement
19 in terms of disclosure needs to be made. For
20 example, you could list all the doctors, the
21 types of doctors that I just listed, and
22 articulate whether or not these doctors have
23 a contract with you as an insurer easily
24 enough. So then again, you're -- how are you
25 holding that hospital out to the patient?

1 The hospital is contracted as well as the
2 other types of providers that typically work
3 in that hospital are also contracted, and the
4 buyer then -- the patient/member, if there's
5 a "no" next to the anesthesiologist, they can
6 turn the page and look to see another
7 hospital to see whether or not all of those
8 hospital-based doctors are contracted.

9 MR. GOMEZ: A quick question on the
10 anesthesiologist because they tend to be the
11 one outlier in most instances for us. When a
12 hospital contracts with a physician and gives
13 them privileges to operate in a hospital,
14 what kind of information are you gathering
15 about that physician? Is there any effort to
16 see whether that independent contracting
17 physician has, in fact, contracts with all
18 the main players and is that entered ever
19 into a database of any sort? Because
20 obviously for billing purposes, the bills get
21 out.

22 MS. DICUS-JOHNSON: We don't bill
23 for these hospital-based doctors? These
24 doctors --

25 MR. GOMEZ: They bill their own

1 services?

2 MS. DICUS-JOHNSON: They bill their
3 own services.

4 MR. GOMEZ: They bill their own
5 services?

6 MS. DICUS-JOHNSON: That's the
7 experience in our system.

8 MR. GOMEZ: So in your view what
9 precludes the hospital system from knowing or
10 requiring, on the condition of providing
11 privileges, that they also provide, you know,
12 that the doctors are required to provide, you
13 know, a list of who they have contracts with,
14 so that the hospital system would know?

15 MS. DICUS-JOHNSON: I don't think
16 there's any -- let me just take a step back.
17 We have a business need to have our
18 hospital-based doctors contract with the same
19 entities and insurers that we contract. I
20 mean, we're completely aligned with that, but
21 they still have freedom to contract. And one
22 of the issues that they say -- that their
23 position on this is that they have the
24 ability to be able to contract with
25 managed-care organizations in terms of what

1 they are going to accept as their
2 reimbursement. So the question is, do we
3 have an incentive to request that information
4 from those physicians. Absolutely, and we do
5 what we can. But we do not employ them, and
6 we can't require them to take less --
7 basically dictate the terms of their contract
8 with a third party. They have to be able to
9 negotiate to their own rates.

10 MR. GOMEZ: But this rule requires
11 only two things, the name of the provider and
12 whether they have a contract, not the terms
13 of the contract.

14 MS. DICUS-JOHNSON: I understand
15 that. But my point is the fact that -- I
16 tried to articulate an example where one day
17 we had particular hospital-based physicians
18 that had contracts, the next day they didn't,
19 and we found out about it happenstance. We
20 don't have the ability to show --

21 MR. NEPPLE: I understand your
22 concern on the practical issues of how to
23 manage a system. But if this issue were
24 addressed on more of a system basis rather
25 than a patient-by-patient individual

1 requirement, might that address your concern?
2 In other words, if the requirement where we
3 articulated the provider has to maintain an
4 appropriate system that is reasonably
5 designed to be up to date, to provide notice
6 to the patient, not that you have to do it
7 right every time and we have to know the date
8 that the contract changes, but you have to
9 have a system so at least within 30 days a
10 change is put into the system and a notice is
11 given, would that address some of your
12 concerns?

13 MS. DICUS-JOHNSON: No. Because
14 that still is an additional administrative
15 requirement that we would have to comply with
16 when the party who's in the best position to
17 have that up-to-date information can have
18 that -- I mean, on the directory they can
19 take the phone calls for precert -- insurers
20 are in a better position to provide that
21 information, not us.

22 MR. NEPPLE: So you don't feel the
23 provider should have any problem with
24 identifying -- subject to some reasonable
25 points that have been made with the course,

1 the procedure may change and different
2 providers might be involved. You don't feel
3 any problem with providers identifying the
4 service providers who would be involved in a
5 particular course of treatment, so that
6 patient, in your scenario, would go back to
7 the insurer and say are these in-panel or
8 not?

9 MS. DICUS-JOHNSON: We don't have
10 an issue with the patient coming in being
11 told these are the types of providers who are
12 going to be rendering care in this particular
13 procedure or this particular episode of care.
14 The types of provider -- what we do not --
15 what we object to is we have to give further
16 information about whether or not these types
17 of providers have contracts with the
18 insurance carrier.

19 MR. NEPPLE: Just to continue that.
20 Again, as opposed to types, but names of
21 providers so that the patient would know, you
22 know, is Dr. Jones who's going to be the
23 anesthesiologist, and in your scenario would
24 go back to the insurer and check their
25 directory, is Dr. Jones in fact an in-panel

1 anesthesiologist.

2 MS. DICUS-JOHNSON: We would have
3 an objection to that because that doctor
4 would have to know that Dr. Jones has call on
5 this particular day. What we could provide
6 is the name of the medical group that -- for
7 anesthesia, you know, ABC Medical Group is
8 our anesthesia group that provides -- that's
9 how are system works -- and most systems
10 require these hospital-based doctors to form
11 as a group and that would be something that
12 we can provide information to. And back to
13 what I said earlier in terms of listing the
14 hospital and whether or not these services
15 the group can be named so it doesn't matter
16 if it's Dr. Jones or Dr. Smith on any day,
17 that particular -- any services would be
18 provided -- anesthesia services would be
19 covered.

20 MR. NEPPLE: Just to further
21 explore the matter. You indicated that the
22 ancillary providers largely do their own
23 billings. Does the hospital provide data to
24 the ancillary providers that's used in their
25 billing systems?

1 MS. DICUS-JOHNSON: No.

2 MR. NEPPLE: They don't have an
3 electronic interface for there was this
4 surgery on X date?

5 MS. DICUS-JOHNSON: Currently, no.
6 Our system -- I can only speak for our
7 system. We're working on an electronic
8 medical record, but currently if there's
9 anything we give back and forth in terms of
10 medical records, I'm not aware
11 electronically. But I believe that the
12 respective physician takes their own notes
13 and forwards it, maybe get medical records,
14 and forwards it to the respective billing
15 agency, but I don't believe that we have a
16 significant involvement in that process.

17 MS. MALLOW: Can I just ask a
18 follow-up question? Did I hear you say that
19 the hospital asks or demands that the
20 providers, the ancillary providers, form a
21 group, a medical group, a billing group?

22 MS. DICUS-JOHNSON: What I said is
23 we typically -- in our system, what we
24 typically do is we ask that they form as a
25 group so that we can organize and manage that

1 type of care that's being provided. All of
2 ours are group. I can't speak to other
3 hospitals, but everybody that we contract
4 with are groups.

5 MS. LEITCH: That's not true across
6 the board.

7 MS. DICUS-JOHNSON: That's what I'm
8 saying. I'm talking about our system, that's
9 all I can speak to.

10 MS. MALLOW: Joan had a question.

11 MS. CURRAN: I come from Gundersen
12 Lutheran and we have 450 medical providers,
13 plus when you put our ancillary providers in
14 it I've got 1,500 medical practitioners, 40
15 medical clinics, hospitals, you know, durable
16 medical equipment, you name it, under the
17 umbrella. Because of their rural locations
18 in a lot of places, we have other entities
19 that come in and provide services because our
20 primary function is to provide medical care.
21 And so the premise on where we're coming is
22 that we object in total about this, on
23 confusing the role between the insurance
24 company and their member and us as a
25 provider. And so where we're coming from is

1 that we don't want to assume any of the
2 administrative burden for the insurance
3 company or the member. And when we look at
4 when a member gets charged premiums, the
5 insurance companies take that into account
6 during their premium quotes. So they know
7 how much is out-of-network and those kind of
8 things, and that's what the member is paying
9 for. So what we're asking for is, is that
10 whatever solution there is, is that maybe
11 there's more education to the members about
12 how to find out about participating
13 providers, having access 24/7 to that, so
14 that they get into a hospital situation or
15 whatever, they can make that phone call or
16 something like that. But we really feel that
17 the medical community, at least Gundersen's
18 medical community, needs to be taken out of
19 the realm here because this is not a
20 triangle, this is a relationship between the
21 insurance company and their member.

22 MR. GOMEZ: And that summarizes the
23 Gundersen position.

24 MS. CURRAN: Yeah, it's that, and
25 on the insurance side our health plan is

1 saying the same thing. In other words, they
2 have the contracts, they know the benefits,
3 they're the ones who administer the benefits
4 based on whether it's self-funded or fully
5 insured, what is agreeable under those. The
6 provider does not have any information to
7 that, they're not privileged to that
8 information, nor would they want to be. I
9 think we have over 500 different insurance
10 companies that we bill to. And to know all
11 of that and to track all of that database,
12 it's not even realistic. Our goal is to
13 provide care.

14 MR. NEPPLE: You do appreciate the
15 rule does not require information regarding
16 benefits, just name of the provider.

17 MS. CURRAN: If you're saying it's
18 in- or out-of-network, it is. And if you're
19 talking about making the phone call on
20 deductible. Deductible is part of the
21 benefit structure I believe.

22 MR. NEPPLE: No, what it requires
23 the provider to do is give the name of the
24 providers and whether they're in-network or
25 not.

1 MS. CURRAN: Right. And what we're
2 saying is that we may not know that.
3 Sometimes our members come or our patients
4 come, and they don't have insurance with
5 them. And when you ask them that, they don't
6 have it on admission, and so we don't know.
7 We also don't have access to all of the
8 different networks and portal access and
9 that's in our position paper, expensive to
10 us. This is an administrative cost that we
11 really feel we do not want to inherit.

12 MR. NEPPLE: I did take the
13 opportunity to read your submission and
14 obviously well written and there's a number
15 of points. I would be interested in what
16 your thoughts are though recognizing that --
17 well, put it this way, if the requirement was
18 quite clear that the only information the
19 provider needs to provide is the name of
20 providers who's providing the services and
21 whether they're in-panel or not. You focus
22 quite a bit on the administrative burden of
23 access to portals, getting information
24 regarding the design, deductibles, copays,
25 and so on, and I think we probably all agree

1 that is a very significant burden and it
2 probably would be an issue for the provider
3 essentially interpreting the insurance
4 contract. But again, I think the intent is
5 just the name of the provider and are they
6 in-panel or not. And the rule leads to the
7 patient then, that 800 number call to get the
8 rest of the information.

9 MS. CURRAN: And because we don't
10 always know who's providing care because our
11 physicians are on staff and so they may get
12 sent to surgery or something, but they'll get
13 the surgeon that's on call. Do you see what
14 I'm saying? And so we might not know.

15 The other is that we would not -- the
16 person that's at the desk at the admitting,
17 they may not understand what -- I mean, they
18 get the admitting diagnosis, sometimes if
19 they have it, but they may not know. And so
20 how would they find out? They would have to
21 start making phone calls. Start calling the
22 doc, ask the doc, you know, who else do you
23 think they're going to see, those kind of
24 things. And so at that point of entry, they
25 would not know. And so, yeah, we do object,

1 and we do object to the in- and
2 out-of-network for sure.

3 MR. GOMEZ: You see where the
4 patient is left in that scenario?

5 MS. CURRAN: Absolutely. We deal
6 with it every single day.

7 MR. GOMEZ: All right.

8 MS. CURRAN: We work with our
9 patients, we also -- and part of our
10 contracting guidelines is that if insurance
11 companies -- we have to have administrative
12 guidelines that we use when we contract with
13 any insurance company, and if they are hard
14 to work with, those kinds of things, we do
15 not sign contracts with them, and so we
16 understand where the patients are coming
17 from, and we help our patients as much as
18 possible. But again, we really feel that
19 whatever solution you come up with needs to
20 be between the insurance company and their
21 member, and we'll continue to help our
22 patients as much as we can.

23 MS. STEPHENSON: Kathy Stephenson,
24 Affinity/Network Health Plan. So I contract
25 with two different panels, one with the

1 provider and also for our insurance system.
2 We try very hard to have all of our ancillary
3 providers be in our panel, and they are in
4 our panels, but for our hospitals to know if
5 all of those providers are in, then someone
6 is going to help me learn how to read an
7 insurance ID card with six COBRAs on it
8 because that registrar has absolutely no way
9 of knowing are we applying this panel, this
10 panel, this panel, or this panel to that
11 person. So for example, when these companies
12 are purchased and they've purchased four of
13 these logos, but you know what, they haven't
14 renegotiated all of their contracts so they
15 haven't all rolled, and I get the call from
16 my customer service representative saying,
17 guess what, The pathologist group hasn't
18 finished their negotiation. They just got
19 treated out of plan. Help me. Well, I can
20 only do so much. They had a contract before
21 they got bought, they get bought, I have no
22 control over how quickly they can
23 renegotiate, nor can I even assist with it
24 when they walk in the door to know -- they're
25 having enough trouble determining if we're in

1 the panel, much less which one is primarily.
2 So I find it to be almost impossible for
3 anyone but the actual people paying the
4 claims to answer the question of who's in or
5 out.

6 MR. WIESKE: I guess, you know,
7 this is something that we've dealt with as an
8 insurance company for a long time, all the
9 administrative hurdles. And I don't think we
10 have a problem with the concept of having the
11 patient call the insurer to verify whether or
12 not the providers are in-network. I don't
13 think that's a problem. I think that you can
14 see that the administrative burden as we've
15 discussed from the get-go on all the
16 providers is pretty significant to try and do
17 this. But still we maintain that there's a
18 problem with forcing insurers to pay for this
19 as well. And so, you know, what we believe,
20 I think, is that there should be some
21 disclosure, but we think that at least a
22 general disclosure, not necessarily having
23 the specific providers, maybe indicating the
24 provider groups, maybe having the list of
25 doctors that are available, not necessarily

1 who they're contracted with, so the patient
2 can call the insurance company and verify
3 whether or not there's in-network
4 availability, whether or not this hospital
5 has coverage.

6 I think in the case of the clinic that
7 you suggested, I think it is reasonable to
8 assume that the clinic itself should be able
9 to maintain, have some idea of contracts or
10 at least have some general notice indicating
11 that you may have services that are
12 out-of-network and you may want to discuss
13 this with your doctors whether or not they're
14 out-of-network, you may want to verify before
15 you get care. Because we've had these
16 notices and provider guides for years, we've
17 had these notices inside, certificates that
18 aren't read. We have, you know, first pages
19 in some states, which were, you know, four or
20 five pages long that talked about these
21 issues, encouraging them to call up, and you
22 know, I think part of what we're looking for
23 is a little bit of help and I don't think we
24 need to get as deep involved in this issue as
25 this rule has. I think that's where the

1 problem is. It's much more complicated than
2 I think we initially thought it was going to
3 be. I think a general disclosure by a
4 hospital, saying we have these pathologists,
5 anesthesiologists, radiologists, ancillary
6 physicians who may not be contracted, and you
7 may not get your choice of providers. When
8 they check in, you know, a sign that says
9 that as well so they're aware that this is an
10 issue upfront and then maybe a requirement
11 that physicians provide this notice if
12 there's going to be elective surgery, put
13 that on and require that in the contract.
14 Those general notices, if they receive a
15 specific piece of paper, maybe they read it,
16 maybe they don't, at least they're aware
17 upfront when they do these elective surgeries
18 that this may be an issue, and they can call
19 and verify.

20 MR. GOMEZ: I guess, that's the
21 question, they call and verify. What would
22 they call and verify? We have a tension here
23 where there really isn't much of an interest
24 in keeping a database of names.

25 MR. WIESKE: The PPO networks keep

1 a database of names. For years since, you
2 know, I was a claims analyst in 1993, we had
3 people calling up 24 hours a day, 7 days a
4 week to verify whether or not their providers
5 were a member of the network.

6 MR. NEPPLE: The enrollee doesn't
7 know who the provider is.

8 MR. PATEK: And we've seen that.
9 People will call in and they can't -- they
10 can verify the facility, and that I think
11 isn't the issue that we're talking about.
12 They can verify the facility, and the
13 facility they may be in, but they're never
14 told who these other providers are, and
15 without that information there's really
16 nothing we can do for them because we don't
17 control who arranges that care, as an
18 insurer. You guys do, and if you don't tell
19 the member who's going to see them, we have
20 no way when we interface with the member to
21 help the member understand what's in and
22 what's out. So we're put in sort of a lose
23 proposition.

24 It's interesting we're sort of being
25 painted as the bad guys, but the reality is,

1 we put it on our cards, we have toll-free
2 numbers, we publish directories; we've done
3 about everything we can. The one thing we
4 can't do is we can't control the interaction
5 you have with the consumer and what you're
6 willing to tell them when they do come to us,
7 they have the right kind of information so we
8 can help them.

9 MS. DICUS-JOHNSON: Do you list
10 anesthesiologists, radiologists, and all the
11 hospital-based doctors in your directory?

12 MR. PATEK: No.

13 MS. DICUS-JOHNSON: That's my
14 point.

15 MR. PATEK: We can verify it if you
16 tell them who's going to provide the care.

17 MR. MUZI: Those providers aren't
18 listed because the member has no ability to
19 select them, so there's no reason to put them
20 in there. Some insurers do list out the
21 groups themselves.

22 MS. DICUS-JOHNSON: Well, I guess
23 the question is is what's the purpose of the
24 directory? If the purpose of the directory
25 is only to assist the patient in when they

1 have the opportunity to select a provider, I
2 would agree with the rationale. But if the
3 purpose of the directory is also to inform
4 them about other services, other things, like
5 this particular subject, then I think that
6 the rationale of including that information
7 would serve that purpose.

8 MR. NEPPLE: You're still missing
9 the point, they don't know who the provider
10 is.

11 MS. DICUS-JOHNSON: I'm not missing
12 the link. I understand that when somebody
13 goes into a hospital, they don't understand
14 that the pathologist that they've never met
15 is going to provide services for them and
16 they have no way of picking, I understand
17 that. The question is, though, is if you've
18 got a disclosure, I mean, we can't help them
19 through everything, but if they have a
20 disclosure and directory that these are the
21 types of hospital-based providers that will
22 most likely render care to you when you're
23 inpatient or outpatient and there's some
24 information related to whether or not they
25 have a contract with the insurer for that

1 particular facility, you've put them on
2 notice because if there's pathologist and
3 there's a "no" next to it and they're not
4 listed --

5 MR. WIESKE: The problem comes when
6 you do list those pathologists -- if you do
7 have contracted pathologists, you do have
8 contracted pieces of that. So you get a list
9 there, but none of them are members of
10 your -- none of them work at your hospital,
11 not one of them. You may have a large list
12 and not one of them works at your hospital.
13 So now you've got a list and none of them
14 work at your hospital. You still have the
15 same problem. Patient needs to know upfront
16 from the hospital that you have -- this is --
17 this should be a core responsibility because
18 these people are practicing in your hospital.
19 They need to know upfront when they walk in
20 the door that some of these services are not
21 part and parcel to hospital services. Some
22 of these people don't get care on a regular
23 basis. They don't come in every year or two
24 years, and they have no idea when they walk
25 in to see their doctor and they get wheeled

1 from the hospital room into radiology and
2 have radiology services, they have no idea
3 because even if -- they've never been told by
4 the hospital that now they've entered this
5 new other world that's not part of the
6 network, and that they're going to have
7 additional fees here. My point is is that
8 the hospital should have some responsibility,
9 I'm not saying you have to list every single
10 provider in your contracts, but there should
11 be some responsibility from the hospital to
12 inform patients when they come because we've
13 been unsuccessful. We've tried to do it, and
14 they don't listen to us. We've said it over
15 and over again; they don't listen to us.
16 They don't call, they don't verify, they
17 don't ask questions, they don't read their
18 certificate. We're trying to get it in
19 another way so patients know when they plan
20 these services that they're going to have
21 these additional costs.

22 MR. GOMEZ: They could call you,
23 they could do everything right, but still at
24 the point of service, how would they know
25 whether or not the doctors that are your

1 network, on your list, are going to be the
2 doctors who are going to be providing that
3 service? I mean, what are they going to be
4 asking?

5 MS. DICUS-JOHNSON: They can't
6 know.

7 MR. GOMEZ: They won't know. They
8 can't know. So what could they really be
9 asking?

10 MR. WIESKE: At least part of my
11 goal here, and that is, yeah, I understand --
12 part of my goal here is the pressure right
13 now is to say to the insurer, well, you
14 should just pay for this.

15 MR. GOMEZ: Yeah.

16 MR. WIESKE: And there needs to be
17 pressure at least on the provider or on the
18 hospital, so they know upfront, so there's
19 some pressure on the providers who are
20 providing these services to know that they
21 have to deal with this patient, and that it's
22 non-network and they know upfront and at
23 least they can plan for it. And, yeah, maybe
24 they're paying out-of-network services, and I
25 understand that's not something you like, but

1 at least they know upfront and they can plan
2 for these expenses.

3 MR. GOMEZ: You know they can pay
4 out-of-network services with some disclosure
5 and notice. I mean, fundamentally the shock
6 comes on the Explanation of Benefits which
7 they see for the first time, and they realize
8 half the services they received are
9 out-of-network.

10 MR. WIESKE: Yes.

11 MR. GOMEZ: And that's where the
12 major disconnection comes from. And I think,
13 again, and I understand the tension and the
14 resistance to the idea of pulling data, but
15 you know, when you congregate a medical team
16 and you give people privileges to function in
17 a hospital, and you have doctors doing
18 different kinds of treatment, you have a list
19 of anesthesiologists who are in that
20 hospital -- it is a limited universe of
21 people who you let do anesthesiology in your
22 hospital, you know. It is a list -- there's
23 a limited universe of pathologists that you
24 allow to work in your hospital. So it's
25 within that very finite world that you did

1 list, and it's a finite list, but there
 2 should be some capacity, you know, to at
 3 least let the patient know that this is the
 4 list or this is potentially the doctor who's
 5 going to work on you next week or next month
 6 in any elective environment. Doctors work in
 7 teams. I mean, it's not as if -- you know,
 8 there are doctors who are on call, we all
 9 know that too, but fundamentally there's
 10 scheduling. There's things that go on that a
 11 patient can -- again, doctors work in teams.
 12 I know this. I know surgeons. My wife's a
 13 doctor. Fundamentally they work in teams,
 14 and they work in clusters, and there may be
 15 some variations of what you might anticipate,
 16 but I just -- I'm having the tension as -- my
 17 problem is I don't quite understand why it's
 18 so hard to say that this surgeon is going to
 19 be working with this anesthesiologist next
 20 week on you. I just don't quite understand
 21 the disconnection. And if the patient is
 22 aware of that upfront, and then, you know,
 23 they make the phone call and they can find
 24 out from any of the insurers whether or not
 25 they're going to be paying significantly more

1 for that treatment or whether they should
2 potentially reschedule their surgery or go
3 someplace so they can save whatever dollars
4 they need to save because the dollars are
5 significant. If we're looking at variations
6 of 5 percent on the overall bill, it would be
7 one thing. But there are situations here
8 where people are walking away from the table
9 carrying the whole load of an out-of-network
10 charge or close to it. Again, that's the
11 other side of -- this is the regulatory side.
12 I'm not necessarily trying to side with the
13 insurers in this because I obviously haven't
14 in many ways in this whole issue, but --

15 MR. PATEK: We were hoping it would
16 be at least one.

17 MR. GOMEZ: Yeah, at least one. So
18 that's the problem I have. I mean, I
19 understand we're all trying to get along with
20 this issue. But the fundamental problem is
21 the patient should be able to know who is
22 going to work on them.

23 MR. WIESKE: You know, a general
24 disclosure. If they provide -- if they
25 provide, you know, in both cases a general

1 disclosure, and the patient wants to
2 investigate more, they can certainly provide
3 a list if somebody asked, they could provide
4 a list of the anesthesiologists that are
5 contracted with the hospital, not their
6 networks, but include a list of ones that
7 possibly could be. They could certainly call
8 up in that case, if they want to investigate
9 further and see.

10 The point here is I understand the
11 administrative burden. Maybe the way to get
12 around that is to make sure to have a general
13 disclosure that says these people may not be
14 members of your network. We have no idea,
15 call your insurer and see.

16 MS. DICUS-JOHNSON: But how do you
17 operationalize what you just articulated
18 because --

19 MR. WIESKE: The HIPAA privacy
20 notices that they sign every day of the week.
21 Every time I go into the doctor's and dentist
22 office, you have to provide a HIPAA privacy
23 notice. I get them in the mail all the time.
24 There's no reason you couldn't require them
25 to sign the same kind of thing.

1 MS. DICUS-JOHNSON: Excuse me, but
2 let's talk about how the process works in
3 terms of the patient/physician relationship,
4 and how this happens. We're talking about
5 this at a high level. Let's drill it down to
6 the person that's been told that they now
7 have to have some type of surgery. The
8 anesthesiologist -- probably a bad example.
9 They may know who the anesthesiologist is
10 that they're going to work with, but they may
11 not know the pathologist. They have to know
12 the schedules of all these other physicians
13 in order to be able to articulate Dr. Smith,
14 Dr. Jones, these are all the people that are
15 going to be providing care to you. Now at
16 that point, what does that person do with
17 that information? Typically what happens,
18 they want to know what hospital is contracted
19 with their particular system. That's the
20 first place they're going to go to, so why
21 not at that time when they're verifying that
22 they've just been told that they need to go
23 to whatever hospital, and they're going to
24 verify it with their plan, why is it that
25 they can't be told at that time by the health

1 plan, just so you know, yes, this hospital is
2 in, but this particular hospital doesn't have
3 all the hospital-based physicians contracted.

4 MR. WIESKE: Because we don't
5 necessarily know -- I don't know that we
6 necessarily know. The physicians have a
7 variety of contracts, you know, with a
8 variety of hospitals in --

9 (Reporter interruption)

10 MR. GOMEZ: Rather than the
11 free-for-all, just one at a time, so that we
12 can get all this stuff down and the minutes
13 will be accurate.

14 MS. STEPHENSON: I contract a
15 panel. I have 14 hospitals in my panel, and
16 I will guarantee you if you chose my panel as
17 your employer, every one of those
18 hospital-based providers is in or I will tell
19 you that or not. I know that. Why are we
20 not holding the people with the panels
21 accountable to tell him who's in or out? You
22 have to know that. It's a matter of whether
23 you've disseminated the information
24 correctly, but I certainly can tell you that
25 if you walk into Mercy Medical Center today

1 that your pathologist is going to be in that
2 PPO panel and so is all your other
3 ancillaries, that I haven't gone out and
4 added a hospital and said, oh, but let's not
5 worry about those others.

6 MR. WIESKE: My point isn't that we
7 don't have the information whether or not
8 they're contracted. We may not have the
9 information whether or not they have
10 privileges at every hospital. And I haven't
11 said that we're requiring you to keep records
12 of every insurance contract. All I'm asking
13 is that if you -- that you provide the same
14 sort of disclosure to -- with HIPAA privacy,
15 with everything else, to let patients know
16 that your providers may be out of network. I
17 don't understand why this is such a huge
18 burden. And then if they want to ask, they
19 can ask what providers you have contracts
20 with, so they can verify with their insurer.

21 MS. DICUS-JOHNSON: So we provide
22 that information at the point of service as
23 they're coming into the hospital. Isn't it a
24 little too late for us --

25 MR. WIESKE: At whatever point they

1 request. And it may come from -- if you're
2 scheduling the surgery from the hospital,
3 they can call up at any time. They just need
4 to be aware at -- when they're scheduling the
5 surgery that these charges are a potential
6 and that they may have those.

7 Again, we've provided these notices in
8 every way, shape, or form that we possible
9 can, and people claim that they have no idea.
10 They claim that they have no idea. Why,
11 because the doctors and the hospital don't
12 discuss that issue specifically with them
13 ever.

14 So I guess what we're asking for is some
15 additional help to say, okay, we'll provide
16 this minor little piece of paper that says we
17 may not have every provider you received
18 services from contracted. That's all we're
19 saying.

20 MS. GEIGER: Karen Geiger,
21 BlueCross. I mean, I almost feel like we're
22 trying to solve world peace here. And I
23 don't know that our customers necessarily
24 want world peace. I'm wondering --

25 MR. GOMEZ: That's not true. Sure

1 they do.

2 MS. GEIGER: But I'm wondering if
3 maybe we can try a stopgap measure. You
4 know, maybe have a much more formalized
5 notice requirement, either in our benefit
6 booklet or our provider directory, that sort
7 of goes into it and see if that solves the
8 problem.

9 I mean, I think a lot of bigger
10 insurers -- I know we have a disclosure in
11 our provider directory and benefit booklets
12 that essentially say that if you go to a
13 facility, not all of the providers at that
14 facility are contracted. But maybe it could
15 be something where we could expand it and say
16 if you want, you know, on occasion your
17 scheduling provider may be able to tell you
18 the providers or the groups that may be
19 providing services for you, and it will
20 depend on whether or not they're on call, you
21 know, whether or not they're contracted, but
22 you know, just give them more of a bigger
23 disclosure, you know, on our end to start off
24 with, and then maybe we come back to this
25 later to see if we need to have a more

1 onerous requirement. You know, to see if
2 that reduces the number of complaints.

3 MR. GOMEZ: When people go to your
4 hospital and they sign up for something
5 that's as salacious as a colonoscopy, let's
6 say, and they're going to go in in two or
7 three week or four weeks, are you saying that
8 if they schedule a colonoscopy -- I would
9 assume that the treating physician, the
10 doctor that is going to do the test
11 essentially, is going to have an
12 anesthesiologist working with him, assuming,
13 right? In that very simple scheduling
14 scenario. I go to your hospital, I, you
15 know, I have my doctor tell me that this is
16 what I should do, you're about to turn 50,
17 you have to do all this nonsense, and then
18 you go to the hospital and then you've got to
19 schedule something. And you're saying that
20 it's a big burden to know whether or not in
21 three weeks the doctors who are treating me
22 are going to be in my plan? That's the
23 tension I have with some of this discussion,
24 because again, we're looking in an elective
25 environment, there's a limited universe of

1 anesthesiologists who are going to be in your
2 hospital -- in any particular hospital, I
3 might add, on any given day -- are you saying
4 that that doctor is not scheduled, there's no
5 way of absolutely knowing who that doctor
6 might be?

7 MS. CURRAN: They may know who's
8 going to do the colonoscopy.

9 MR. GOMEZ: They would be your
10 in-network doctor I'm assuming.

11 MS. CURRAN: Pretty much. But it
12 depends on what network they're in. Like I
13 said, we do hundreds and hundreds of
14 insurances and so, you know, I don't know if
15 you're in or out. I think the issue is this,
16 is that -- to that gentleman over there,
17 about who said we talk to them, we talk to
18 them, and we still talk to them, and they
19 don't pay attention, Gundersen not only in
20 their health plan, but also as a medical
21 organization has something that we hand every
22 patient that comes into our hospital that
23 says, you know, insurance is between you and
24 the insurance company. You may have charges
25 that are not a covered benefit. They may be

1 in/out of network, that kind of stuff.
2 You're going to want to definitely check with
3 your insurance company. We also offer
4 financial counseling and say the same thing
5 to them. And they ignore us as well, so I
6 think we have something in common there.
7 People just don't feel responsible for their
8 healthcare, and so we do what we can.

9 MR. GOMEZ: You tell people at
10 financial counseling --

11 MS. CURRAN: We have all our
12 doctors -- when you walk into our lobby, all
13 our doctors are there. You go to our
14 website, all our doctors are there. And what
15 we may not have on there is we may not have
16 some ancillary, like if we bring in somebody
17 to do ablation, that comes into our
18 Heart Institute maybe one or two days a
19 month, they might not be on the front, and
20 stuff. And then do we say to those same
21 patients, you're going to want to check with
22 your insurance company. Whether they do or
23 not is not -- we ask them to do that, we work
24 with them, we remind them that they will be
25 liable for every medical bill. But what I'm

1 saying to you is that won't solve the problem
2 because when they get that medical bill and
3 they haven't checked with their insurance
4 company, what happens is they don't remember
5 any of that. Remember when these people come
6 to our organization, they are overwhelmed in
7 a number of cases. They've had some of the
8 worst news of their life, and their lives are
9 changing very dramatically. And the fact
10 that you're saying to them, you may have a
11 financial liability, is not number one in
12 their mind. And so we can argue in here
13 amongst ourselves, but the fact of the matter
14 is we have a vulnerable population. And
15 we've just got to face that. And they're not
16 going to be able to take in all that
17 information. So we may be trying to solve
18 something that can't be solved until people
19 realize that there's going to be these
20 circumstances, and we all are working the
21 best we can to work around it.

22 The other thing I'd just like to point
23 out is in our facility, we do not upfront
24 share with our doctors what insurance
25 companies we contract with. And the reason

1 is that we believe that medicine should be
2 based on what is the appropriate treatment.
3 And we go by evidence-based guidelines, not
4 insurance coverage. So to assume that our
5 physicians would know that, I think is maybe
6 a wrong assumption.

7 MR. GOMEZ: Marshfield Clinic had
8 some written comments also.

9 MR. PHILLIPS: Robert Phillips from
10 Marshfield Clinic. I'd just like to echo a
11 lot of what Gundersen has said. And I'd also
12 like to focus on the scheduled nonemergency
13 care also because as a physician there are
14 multiple circumstances where patients come in
15 and they need additional testing and it's not
16 a true emergency. As an internist I've had
17 patients come in who've had chest pain, and
18 they need to be evaluated further with an EKG
19 and other appropriate laboratory testing.
20 Now most of our patients fall within our
21 system of care, so we have, at least in the
22 central Marshfield area, the luxury of people
23 provided care by either government programs
24 or the Social Security health plan. But in
25 other centers of our system, that's not

1 necessarily the case.

2 And so, again, I guess from a patient
3 safety and quality standpoint, I'm not sure
4 the rule can address all circumstances where
5 patients need additional care. Colonoscopy
6 is more like a surgical procedure, that is
7 it's scheduled in advance. But when patients
8 come into the office and they're having side
9 effects from medications or they had to come
10 in for their blood pressure and they have new
11 systems of fatigue or abdominal pain that
12 require semi-urgent but not emergency types
13 of evaluation, to put that in the provider's
14 realm of responsibility to have to inform
15 them, and to have them go somewhere else
16 because they're not -- we're not in the
17 network, puts a lot of responsibility on the
18 patient and the physician in terms of
19 quality-care issues.

20 The other thing, because of quality
21 initiatives, as many of our organizations are
22 supportive of, increasingly we're going to
23 see patients that are coming in for
24 preventive services, like colonoscopy, and
25 they may need to have polypectomy at the time

1 of the colonoscopy or they'll have to be
2 rescheduled for it subsequently if it's done
3 by a different provider. We have patients
4 who come in for screening mammograms. It's
5 not unusual to turn up an abnormality that
6 needs further imaging. Again, from a
7 patient's safety and quality standpoint, do
8 you reschedule -- patients come from 150 to
9 200 miles away to our organization -- from a
10 quality and safety standpoint, do we need to
11 get their additional images in-network?
12 Again, this is the kinds of things that at
13 least need to be brought up because we can't
14 regulate for all possible circumstances.

15 MR. GOMEZ: Any other thoughts
16 before we take a break? My initial thoughts
17 are for those who are currently, including
18 Gundersen, using potentially information that
19 you provide patients in this educational
20 process, I think we'd like to see them if you
21 have them.

22 MS. CURRAN: What they hand out
23 when they --

24 MR. GOMEZ: What they hand out.
25 And I guess I'd like to revisit with the

1 insurers, again, trying to find some golden
2 means to this issue. You know there is
3 language that's already proposed, that's on
4 the table. We've got a directive to sort of
5 work on this because it's not necessarily an
6 issue that we can walk away from. We were
7 told by JCRAR that we have to find some
8 solution. So to the extent, Karen, you had
9 some ideas, some sort of mid-ground idea.
10 I'm not entirely sure what a disclosure does.
11 I've been to hospitals with disclosures, I
12 know what they've looked like, but then I'm
13 capable of asking, well, who's really working
14 on me next week, and you know, that's
15 generally the closed-panel environment so
16 it's not a hard call, but, I don't know, it's
17 -- if you have some thoughts as to what you
18 think might be a reasonable, meaningful,
19 insightful, helpful disclosure.

20 MS. GEIGER: Bottom line is it all
21 depends on whether or not the patient is
22 going to read it. But it's going to come up
23 whether we're the ones who are doing the
24 notice or whether it's the hospital. Because
25 I think we can all testify -- I know that I'm

1 the same way with my doctor. I get handed
2 materials and it goes on the seat of the car
3 and the bottom floor of my car, and it never
4 gets read.

5 MR. GOMEZ: Let me ask you, if you
6 were going in for an elective procedure and
7 you got a notice that said doctor X is your
8 doctor, and you've already verified you're in
9 the right plan, you're in the right hospital,
10 but, you know, you'll be potentially
11 receiving anesthesiologist services, it is up
12 to you to verify whether or not this doctor
13 is in your network, otherwise you'll be
14 paying substantially more out of pocket, you
15 may have pathology services, you know, it is
16 up to you to find out whether the pathology
17 services you'll be receiving are in-network
18 or not, otherwise you'll be paying
19 substantially more, with like bold letters
20 that say otherwise you'll be paying
21 substantially more out of pocket, I mean, I
22 don't know -- I mean people understand paying
23 substantially more if they understand they're
24 scheduling an elective surgery. I think --

25 MS. GEIGER: I mean, ultimately I

1 think the question is whether or not I'm
2 writing it as a lawyer, or whether it's the
3 marketing area writing it.

4 MR. GOMEZ: There's always
5 compliance and there's always marketing.
6 Really the issue is what do people really
7 know when they go in and schedule something.
8 And our experience here has been they don't
9 know as much as they should know. Now there
10 could be a lot of bury your head in the sand,
11 and people are traumatized, but that only,
12 from my perspective, gives me greater
13 ammunition for arguing that they have to
14 absolutely know. Then the second wave of
15 trauma comes about three months later when
16 the EOB comes in and then, you know, we're
17 calling, you know, all these insurers around
18 here and giving them a hard time and saying
19 it looks like you have to cover this.

20 MS. CURRAN: But the time to learn
21 it is when they're getting their enrollment
22 material. That's the time to learn it.
23 Because nobody is in trauma then. And I bet
24 if you went out to an employer group or even
25 in your own insurance company, how many of

1 your folks, other than maybe your claims and
2 compliance department, have read their
3 Explanation of Benefits or their summary of
4 coverage, I bet that five hands would go up.
5 And I happen to be a State of Wisconsin
6 employee because my husband's at the
7 University -- I know that will get you
8 started.

9 MS. MALLOW: But we have a really
10 nice book that explains our benefits.

11 MS. CURRAN: Yes. Even before I
12 did anything with insurance, I read those
13 things cover to cover so that I would know
14 when I need services. So maybe that's where
15 we look at is that we move this education up
16 front because that's probably when people are
17 most interested in what does this mean for my
18 family's finances.

19 MR. WIESKE: Unfortunately, it's
20 already there. It's there today. You know,
21 you can quote the sections -- having done
22 appeals, again, years ago -- you can quote
23 these sections rote from the certificate of
24 coverage indicating this is the way this is
25 covered and here it is, right in your

1 certificate. And so it's there. People
2 don't expect to have to receive, they don't
3 expect to have to utilize the care. So we've
4 tried to educate them as best we can.

5 And as I stated before, you know, maybe
6 it would help to have another point of entry,
7 yes, it's another HIPAA privacy issue
8 potentially, but a generalized notice saying
9 that, you know, if you receive care, you
10 should investigate it. Seems to me to at
11 least, you know, get them to at least ask the
12 questions. Maybe they don't read that
13 either. Maybe it's just another piece of
14 paper. But at the point that they're
15 planning on having elective surgery, if they
16 have that from the doctor and the hospital,
17 it seems to me they at least have the
18 incentive to investigate.

19 MR. GOMEZ: Before you get off the
20 hook, do you have any proposed linguistic
21 ideas how your thoughts could be articulated.

22 MR. WIESKE: Not specifically.

23 MR. GOMEZ: But could you come up
24 with some?

25 MR. WIESKE: Sure.

1 MR. GOMEZ: I know that Dan had a
2 point earlier.

3 MR. SCHWARTZER: Just a general
4 comment. And if J.P. submits examples,
5 proposed language --

6 MR. GOMEZ: You're all free to do
7 that.

8 MR. SCHWARTZER: Just from our
9 association's official position, one of the
10 reasons that we went to JCRAR was because of
11 this exact reason, this very difficulty
12 situation. We don't believe that -- we
13 believe that one of the options here is to
14 simply say that the market needs to continue
15 to try and improve and that no regulations on
16 this will exist. That's one of the options,
17 at least from our perspective walking into
18 this and talking with JCRAR. We have
19 started --

20 MR. GOMEZ: That option is not on
21 the table. That's the old option.

22 MR. SCHWARTZER: That's the old
23 option. Well, it's the current option right
24 now according to the legislature. But the --
25 we've started negotiations with the hospital

1 association in terms of what they could
2 provide for notices, and we think that those
3 talks have been fruitful, and we think that
4 they're going to continue and the hospital
5 association is going to come up with some
6 type of recommendation. We believe that we
7 want to continue those discussions.

8 From our official position -- I just
9 want to make sure this is on the record -- is
10 that we think that one of the options is to
11 let those talks happen with the hospital
12 association, let that information develop in
13 terms of what they can provide and what we're
14 already currently providing, and let the
15 market work.

16 MR. GOMEZ: What are you already
17 currently providing? What do you mean?

18 MR. SCHWARTZER: The information
19 that I think you described before which is a
20 benefit booklet and a directory that says at,
21 you know, St. Matthews these are the services
22 we have contracted with the hospital there.
23 They are owned by the hospital and/or we have
24 contracted with their anesthesiologist or
25 contracted an anesthesiologist, so that if

1 you see anesthesiology as one of the
2 contracted services at St. Matthews, then you
3 know that if you see an anesthesiologist,
4 it's going in-network, but because we don't
5 have radiology covered or contracted, that
6 means that's going to be an out-of-network
7 service. So from our perspective, we're
8 providing that information upfront --

9 MR. GOMEZ: Let me ask you, are
10 there environments where you have the whole
11 litany of ancillary services covered? I
12 mean, I'm assuming you should be able to send
13 a policyholder to a hospital that has
14 radiology, that has in-network, the whole
15 deal in-network. How do they find that out?
16 How do they really find that out at the
17 points of service? How do they know in the
18 vast spectrum of choices, how do they know?
19 You just described that you have
20 anesthesiology in-network, but radiology is
21 not.

22 MR. SCHWARTZER: We have a
23 disclosure --

24 MR. GOMEZ: You're saying we want
25 you to go to this hospital to do these

1 services, and it is quite possible that
2 radiology is going to be one of the needed
3 services --

4 MR. SCHWARTZ: Right.

5 MR. GOMEZ: -- why is it that
6 you're not saying, what you really need to do
7 is go to this other hospital that has
8 radiology, anesthesiology, all this other
9 stuff that you're probably going to need.

10 MR. SCHWARTZER: I think that we do
11 give them that option. We explain upfront
12 that not all ancillary services are covered,
13 that you need to look at the directory and
14 determine which services at which hospitals
15 are available and then you need to make a
16 rational decision as to what facility you
17 want to use based on what you know is covered
18 and what isn't covered.

19 The argument that we made years ago was
20 that what we felt the hospitals and the
21 doctors -- we're leaving them out and it's
22 extremely important that they're involved --
23 but what they should provide to their
24 customers is a list of the services that they
25 subcontract. If they subcontract for a

1 certain service, the patient should know that
2 that service is not an in-hospital owned
3 service, it's subcontracted, and who it's
4 subcontracted with.

5 I will state, though, for the record,
6 that we don't believe that that need should
7 or is appropriate in an insurance regulation.
8 If that's going to occur, if people believe
9 that's the route that needs to go and it
10 needs to be regulated, then it needs to be
11 regulated by the DHFS or there needs to be
12 statutes written for it, but certainly not an
13 insurance --

14 MR. GOMEZ: And who are they
15 contracting with? I mean, just talk -- that
16 thought is precisely the resistance that's on
17 this side of the table. I have no issue and
18 we don't generally have any issue with what
19 you just said. Tell us who you're contracted
20 with. Go to the point of service and tell us
21 if this doctor -- who's the doctor, so I can
22 check to see whether or not they're in your
23 plan. There's no disagreement on that. And
24 in the absence of any regulatory oversight,
25 that has been the issue. And obviously we're

1 in an environment where that information is
2 currently not being provided and the
3 resistance to provide it is quite heavy, so
4 that's the tension. And regardless of where
5 this whole package really fits, that's the
6 issue we're trying to get here and find some
7 sort of middle ground as to what the patient
8 should try to get when they're getting
9 services. We don't -- I don't disagree with
10 anything you just said. The question is, how
11 do you make that work?

12 MR. SCHWARTZER: Well, I think
13 you --

14 MR. GOMEZ: If your literature says
15 these are the docs, this is where their
16 hospitals are -- you're in plan, you're in
17 plan, you're in plan, and then you go to a
18 hospital that's in-plan and then a bunch of
19 stuff is not in-plan, that's the
20 disconnection. They need to be able to make
21 a choice, wouldn't you agree?

22 MR. SCHWARTZER: Yes, and I think
23 that they're given that information at the
24 point of sale up front.

25 MR. GOMEZ: Things change, new

1 physicians come in, new anesthesiologists
2 come in, new pathologists come in, you
3 know --

4 MR. SCHWARTZER: And again, I think
5 someone mentioned before that it's not the
6 hospital's position to tell you who's in and
7 who's out-of-network. And I would agree with
8 that. I don't want the hospital saying
9 whether or not one of their ancillary doctors
10 has coverage or is an in-network provider
11 with one of our PPOs, it's the insurer's
12 responsibility and the network's
13 responsibility to say Dr. John Doe is
14 in-network or not in-network.

15 MS. MALLOW: And Dr. John Doe is
16 in-network at one hospital and not in-network
17 at another, can they answer that question?

18 MR. SCHWARTZER: Absolutely. With
19 an 800 number, absolutely.

20 MR. GOMEZ: Once they know what
21 doctor.

22 MR. SCHWARTZER: What's that?

23 MR. GOMEZ: Once they know the
24 doctor's name.

25 MR. SCHWARTZER: Right. Once they

1 know the doctor's name or the group.

2 MR. PATKE: But without that, we
3 can't --

4 MR. SCHWARTZER: It's not across
5 the board, but in many instances you contract
6 with a radiology firm and the firm is
7 contracted and all the doctors under that
8 firm are contracted. In other circumstances
9 when you don't have -- when the hospital
10 doesn't have the full radiologist firm under
11 their contract, that isn't necessarily the
12 case.

13 MS. DICUS-JOHNSON: But I'm
14 confused as to why this can't be done at the
15 point of contracting in terms of you -- when
16 you contract with any of these physicians,
17 you credential them, so you know where they
18 have privileges, you have this information,
19 and why can't there be a link between the
20 name of the hospitals and -- right there.
21 Elmbrook Memorial Hospital, we have all of
22 the hospital-based doctors contracted. Why
23 is it so difficult to put that all in one
24 place? Because people in the scenario you
25 just described, the deductible and

1 coinsurance issue, that's when -- when
2 they're going to go and have anything done at
3 the hospital, that's when it's going to hit.
4 So they're going to want to know if they're
5 going to go to Elmbrook, ProHealth, one of
6 their hospitals, that's when they're going to
7 want to know. They're going to go to their
8 book and they're going to look at it. This
9 is a contracted hospital, oh, by the way,
10 Elmbrook has all of the hospital-based
11 doctors contracted. I don't understand why
12 that can't be in one format in a directory
13 online or something because you have all that
14 information.

15 MR. SCHWARTZER: Well, it is in the
16 directory.

17 MS. DICUS-JOHNSON: It's all over
18 the place. You've got the doctors over here
19 and you've got the hospitals in one section,
20 and that goes to your issue about having to
21 know who the doctor is. But if you put it
22 all in one format where all of the hospital's
23 provider-based doctors that are rendering
24 services in that facility, it's all in one
25 spot, then they don't have to look through

1 the directory to identify who's in -- you
2 don't even have to know the name of the
3 doctor.

4 MR. SCHWARTZER: How big do you
5 want the directory, though, because for
6 Elmbrook it might be those -- the doctor you
7 have contracted, that we have contracted, but
8 those doctors have admitting privileges at
9 another hospital, so you're going to be
10 listing the doctors three and four times
11 rather than --

12 MR. WIESKE: Why is it so difficult
13 for you to provide a list of doctors who are
14 contracted at your hospital?

15 MS. DICUS-JOHNSON: I've just
16 articulated, because it's a moving target.

17 MR. WIESKE: But not their
18 contract, whether or not they're there on
19 that. You can't tell me -- if I call you up,
20 you can't tell me whether or not a
21 pathologist is contracted, has privileges in
22 your hospital? You can't tell me who has
23 privileges?

24 MS. DICUS-JOHNSON: Again, we
25 provide that information. Again, I think we

1 have to take a step back and say to ourselves
2 at what time is this information relevant to
3 the patient. They are making the decision
4 about what hospital they're going to go to
5 not when they're walking through our doors.
6 It's less relevant at that time in terms if
7 they're going to be making any decision.
8 They need to know in advance and you -- and
9 most of the stuff is online anyway. You can
10 link it back and forth in terms of this, you
11 know -- you've got this information already,
12 so why not --

13 MR. SCHWARTZER: Because you just
14 said it was a moving target, and it is a
15 moving target. So you've contracted with
16 Dr. John Doe as a radiologist, and Dr. John
17 Doe leaves, okay, it is a moving target, but
18 you know when Dr. John Doe is no longer your
19 radiologist anymore.

20 MS. DICUS-JOHNSON: What I said was
21 a moving target is whether or not these
22 independent physicians have contracts with a
23 third party.

24 MR. WIESKE: We don't care about
25 that. I'm not talking about a third party.

1 I'm talking about only your list of
2 physicians.

3 MS. DICUS-JOHNSON: I'm trying to
4 phrase the issue differently. The issue that
5 I'm phrasing is that the information that's
6 available, what are you going to be doing
7 with this information. And if you started
8 this at the very beginning, deductibles and
9 coinsurance choice, when they're walking in
10 the door -- if I do what you've asked to do,
11 it's too late. My point is is if we're going
12 to address the issue, then do it upfront and
13 do it in the information that you provide to
14 these members at the time that they're
15 getting all their membership material.

16 MR. SCHWARTZER: It is.

17 MS. DICUS-JOHNSON: And when they
18 go back to look at it, when they've been
19 told -- when the doctor says I have admitting
20 privileges, the person typically goes to make
21 sure that Elmbrook is in-network. They can
22 look and say, all of the hospital-based
23 physicians, in addition to all of the
24 disclosures that you're making.

25 MR. WIESKE: But it's not -- the

1 problem is when -- let's assume that it works
2 perfectly. You're scheduling the surgery,
3 they get a notice from their physician as to
4 where it's going to be scheduled, okay? So
5 they're doing this upfront. They want to go
6 to your hospital, we certainly have a list of
7 radiologists and pathologists, so on and so
8 forth that are available that may practice at
9 your hospital, but as indicated, some of them
10 aren't necessarily in the entire practice
11 group. They may contract -- each physician
12 may contract separately. So they don't
13 necessarily know whether or not from the list
14 of -- from our list whether or not all of
15 them -- it's not an all-or-nothing deal.
16 They may not know all of them are available.
17 What I'm saying is if they called up your
18 office, could you provide them with a list of
19 pathologists so that in case they aren't
20 listed currently in the directory, they can
21 verify whether or not they've become
22 contracted or something along those lines.

23 All I'm talking about is a general
24 notice. It goes out from a physician, a
25 general notice that goes out from a hospital

1 when the surgery is scheduled, that gives the
2 individual the opportunity to investigate
3 further. Now we may have those people listed
4 in the directory and we may have them listed
5 in a similar way to what you're talking
6 about, but we may not have a complete list.
7 So they should be able to call up the
8 hospital and see some sort of list of
9 ancillary providers that have contracts that
10 may receive services so they can, in fact,
11 call and verify, assuming we've done upfront
12 that this is listed in the provider
13 directory. We have surgical directories
14 online typically. We have all kinds of
15 information available to the consumer, but if
16 they can't -- but, you know, if you can't
17 tell them -- if you have no idea what
18 pathologists are available, if you can't tell
19 them what anesthesiologists are available, if
20 you can't tell them what radiologists are
21 available from an entire list, there is no
22 way for them to verify and we can't have a
23 discussion here. It's game over. They have
24 no way to verify, no way to discuss, no way
25 to call and verify because, you know, these

1 people may have multiple -- may not be listed
2 in the directory, so they can't call.

3 MS. DICUS-JOHNSON: I think I'd
4 like to reiterate what Karen said earlier
5 about can we take baby steps to fix this
6 problem to some extent and reduce the issue
7 versus solve it. Because I can only speak
8 for our -- we can have everybody in a
9 particular group -- let's just take our
10 system -- if we had a contract -- our
11 contract with BlueCross required us to
12 provide information about all the physicians,
13 hospital-based physicians that practiced in
14 our hospital. At the time of contracting, we
15 could do that, and they could then list that
16 in their database and they could also provide
17 that information in the directory. That's
18 something that we can do. But to require us
19 to do that at the time that services are
20 being provided, when the person that's
21 registering the person -- and I'm
22 reiterating, you know, what network or -- and
23 I hear your point about the issue about the
24 physicians so I'm not disputing that, but
25 there are so many other administrative issues

1 that we have to comply with just to provide
2 services and to get paid for them, to add
3 another requirement on top of the list, I'm
4 going to tell you, we're not going to
5 accomplish the goals that we're trying to set
6 out here, and that is to reduce the issues
7 associated with these patients getting caught
8 in the middle.

9 So the solution we're trying to
10 articulate, maybe not so artfully, is we
11 think that plans need to do a better job
12 about the proximity of the information that
13 they put together, how they compile it, and
14 how they provide the information in terms of
15 the disclosures so that when they have a high
16 deductible plan or regardless of what plan,
17 they go to that directory to look for their
18 hospital and they can see, Warning, this is a
19 hospital that doesn't have all of the
20 hospital-based doctors. They can make a
21 decision based on that information.

22 MR. SCHWARTZER: We do that now.
23 That's what we're trying to say.

24 MS. DICUS-JOHNSON: You guys may do
25 that, but I don't think that's standard

1 across the board.

2 MS. GEIGER: The issue we probably
3 have dictating, like moving certain providers
4 underneath other providers, I don't know that
5 we could do that systematically. Right now
6 -- I mean we're set up that way, you know we
7 pull the data through our contracting
8 physicians, but if we had to say here's
9 Elmbrook Hospital and here are all the
10 providers that are contracted with Elmbrook
11 Hospital, you know, within the provider
12 directory I'm sure we can give it when people
13 call up, but you know, we create a provider
14 directory, we have all that --

15 MR. WIESKE: It's nice to tell us
16 that you can't do anything administratively,
17 it's all on us.

18 MS. GEIGER: That's not what I
19 said.

20 MR. WIESKE: But there's some
21 responsibility on the part of the hospitals,
22 I think, to inform patients. That's what I'm
23 talking about, a generalized notice to inform
24 patients that they have subcontracted
25 services that may or may not be part of the

1 network. That's the limit of what I'm
2 talking about. It seems to me to be a
3 reasonable requirement, that they're aware
4 when they walk in the door that, you know,
5 that they may be walking into the world of
6 radiology, and when they're walking into
7 another world it may or may not be
8 contracted.

9 MR. NEPPLE: Your proposal
10 includes, what I've heard described on this
11 side of the table, provides an online
12 provider directory that's sorted for
13 ancillary providers by facility.

14 MR. WIESKE: I don't know the
15 feasibility of that. I have no idea. Karen
16 indicated they'd have problems with that.

17 MS. GEIGER: I mean, I haven't
18 looked it up. You know, an anesthesiologist
19 could work at multiple hospitals or at least
20 their group might, and to say that, okay, you
21 know, you're listed here with this hospital,
22 with this hospital, with this hospital, I
23 mean, it's just going to be a size nightmare.

24 MR. NEPPLE: I'm perhaps a little
25 confused when you get an enrollee calling on

1 your 800 number and asking --

2 MS. GEIGER: Well, calling is no
3 problem. I mean, we're talking the actual
4 provider directory.

5 MR. NEPPLE: We're talking about an
6 online system, not necessarily a directory --
7 let's put the directory aside for a minute.

8 MR. WIESKE: You'd be able to look
9 at the name, the region, their address, and
10 those sorts of things. You may have some --
11 I don't know if they have information as to
12 the hospital they practice at or not.

13 MR. SCHWARTZER: Some do, some
14 don't.

15 MR. NEPPLE: So when somebody calls
16 an 800 number and says Dr. Jones is going to
17 be my anesthesiologist --

18 MR. WIESKE: We can absolutely,
19 whether or not it's --

20 MR. NEPPLE: -- you don't know
21 whether they'll be in-panel or not?

22 MR. WIESKE: No, no.

23 MR. SCHWARTZER: An 800 is an
24 absolute confirmation. I'm seeing this
25 doctor, at this hospital, at this location,

1 they know exactly.

2 MR. WIESKE: We have the name, we
3 absolutely know whether or not if they're
4 contracted.

5 MR. NEPPLE: And including at which
6 hospital.

7 MR. SCHWARTZER: Yes.

8 MR. NEPPLE: So it could be an
9 online directory.

10 MR. PATEK: Well, I don't know if
11 that's true over time. We may know when we
12 credential them, but one of the issues we
13 have is, you know, if the hospitals claim
14 they have difficulty getting out of their own
15 contractors what they're up to, we have even
16 more difficulty because we're one step
17 removed. We have physician groups that don't
18 tell us that they've changed affiliation
19 groups. They lag significantly in time so --
20 one of the issues, I guess, then would be, if
21 we're going to do that, if we're going to go
22 through the work of connecting them, if they
23 fail to notify us, they ought to be
24 responsible for eating the balance because
25 they failed to notify the member by failing

1 to notify us.

2 MR. NEPPLE: I assume you attorneys
3 will draft an appropriate contractual
4 agreement.

5 MR. PATEK: Well, that's the whole
6 discussion in the beginning of this. They
7 limited -- your authority is to put the
8 burden on us, but at the end of the day
9 putting the burden on us and having us absorb
10 additional costs simply means the member pays
11 because the provider they see don't disclose
12 who's going to provide the care, which means
13 the members, the network loses both ways.
14 All you've done is shift from an EOB surprise
15 to more premium costs on their part, so I
16 guess, you know, the member is seeing a
17 facility, the facility has them sign a
18 financial commitment, and that financial
19 commitment is held by those ancillary
20 providers as their commitment, but yet
21 they're totally unknown to the member in most
22 cases. So even if the member is doing the
23 right things, you know, we're paying the
24 bill. So I -- if we don't get updates, that
25 system is not going to work either, and that

1 is the issue.

2 MR. NEPPLE: That's a little bit
3 different description than I heard earlier.
4 You're saying that the facility obtains the
5 commitment to pay the ancillary provider's
6 bill?

7 MR. PATEK: At least every case
8 I've ever seen, the financial commitment that
9 an ancillary provider holds out to you is the
10 one you signed at the hospital you entered,
11 not one that you signed specifically for
12 them. It's the one you sign with the
13 hospital that you enter or the treatment
14 facility you enter. That's the one they
15 claim entitles them to balance bill members.
16 That's what we see in disputed cases where --

17 MR. NEPPLE: So at least we agree
18 there is a billing relationship between --

19 MS. DICUS-JOHNSON: I would argue
20 that there's clearly a contract issue related
21 to that point. Not to put my lawyer hat on,
22 but as it relates to whether or not in that
23 particular instance that could apply, but
24 that's another issue. We obviously go
25 through it and we're representing it at the

1 hospital, and I don't have a copy of what it
2 looks like now. I would be happy to do that,
3 in terms of what it specifically states on
4 there with regards to anesthesia and all
5 those other services.

6 MR. NEPPLE: Would you care to
7 provide us a copy?

8 MS. DICUS-JOHNSON: Absolutely.

9 MS. CURRAN: I have a question more
10 than a comment. Here's my question, we seem
11 to be spending a lot of resources and time.
12 How big is this issue? Out of all the
13 grievances, how many grievances did OCI
14 receive, and how many of them pertain to this
15 issue, in the last 12 months?

16 MS. MALLOW: We can get the number.

17 MS. CURRAN: Can you provide that?

18 MS. MALLOW: It's more than you
19 would think. And some of the stories are
20 horrendous in terms of how much money people
21 are out of pocket and how shocked they are
22 when think get their bills. The one that I
23 always trot out and can't tell you how common
24 it is, the woman who knew she was going to
25 have a scheduled C-section, made sure the

1 doctor was in-network, made sure the hospital
2 was in-network, made sure the
3 anesthesiologist was in-network. Nobody told
4 her that because it was a scheduled
5 C-section, she had to have a neonatologist in
6 the room. That person wasn't in the network,
7 and that bill was a shocker. And I think
8 that brings home what happens here, is that
9 the patient doesn't necessarily know who's
10 going to see them. This was a hospital
11 policy, so the hospital knew ahead of time
12 that there was going to be that provider in
13 the room, nobody told her. So she didn't
14 have any ability to check on it until she got
15 the big bill at the end. And it always ends
16 up being the patient's responsibility.

17 MS. CURRAN: Especially if they're
18 non-par they have that right to balance bill.

19 MS. MALLOW: Right. But how does
20 this patient know ahead of time? This was
21 somebody who actually tried very hard to do
22 the right thing, and still didn't have all
23 the information she needed, and still wasn't
24 given the information she was needed.

25 MR. GOMEZ: Most of our examples,

1 and again this has been a lingering issue for
2 several years. I've only had to live with it
3 for two and a half years, probably will be a
4 full three years by the time it's all done,
5 which is three years too much for my taste.
6 Most of these examples we've had we've
7 debated over, are precisely these kinds of
8 examples. That somebody does go to the right
9 facility, and at least has the initial
10 contact with the right doctor or the right
11 physician group, and then the rest of it
12 falls apart. So that's been the ongoing
13 disconnection, and I think most people will
14 probably agree with that because we've had
15 lots of evidence of that and lots of
16 different examples of that.

17 So to the extent that we kind of dump on
18 patients for not going to the right place and
19 not knowing enough, most examples -- we're
20 addressing the question of when they do
21 everything they're supposed to try to do,
22 anything within their control when they have
23 the information that's available to them they
24 use it as appropriately as they possibly can,
25 then they go into the black hole, and then

1 they get the EOB shocker because they didn't
2 realize that all this other stuff was not
3 going to get covered the same way. That's
4 what we have examples of, and that's what
5 we're trying to address in this. We're not
6 looking at the patient who knowingly goes to
7 a hospital out-of-network, they know that,
8 they didn't do any due diligence, they know
9 that doctor isn't in-network. We have those
10 examples too and they're not part of this
11 discussion, and in fact we have a lot of
12 those complaints and we didn't do anything,
13 but the rest of it is. And that's really --
14 as circular as this hole has become, it is
15 the instance where the patient does
16 everything pretty much right, they get the
17 directory out, they go to the right place,
18 and that's what's going on. And I think the
19 last several years of consumer-driven
20 healthcare and that other stuff has made
21 patients much more cognizant of the financial
22 impact of making the wrong choices. I think
23 really with one renew period they know what
24 the difference is. Now that they have a
25 \$1,000 deductible plan or \$500 per kid or

1 whatever it is, they know the difference.
2 And so I don't know if the patient education
3 component is missing here. The reality is
4 the patient doesn't know. And if they did
5 know, they would maybe make some different
6 choices, and maybe they wouldn't. Maybe
7 they'll say, you know what, I want to be in
8 this hospital, I wanted to be treated by this
9 anesthesiologist. I don't care if he's
10 out-of-network. They can make those choices
11 too, but my general sense is that with all
12 the expenses that are flowing out of their
13 pocket, they would probably be inclined to
14 wait for the right doctor or go to the right
15 facility if they have the information.

16 MS. DICUS-JOHNSON: I would be
17 curious to know, though -- I mean, I can only
18 poll some of our hospitals -- how many
19 hospitals with pairs have all of those
20 ancillaries, all those hospital-based doctors
21 contracted, because I think it's very spotty.
22 I think that at the end of the day in terms
23 of all of this information and everything,
24 that the onus from the insurer's perspective
25 is that it's hit or miss. They don't have

1 them all. So you may have the
2 anesthesiologist covered, but you don't have
3 the pathologist. You may have the
4 radiologist and the -- there's going to be
5 one hole there that they won't have. I think
6 it's the exception versus the rule in terms
7 of having all of those hospital-based doctors
8 covered. Because what happens is if they
9 can't get the rates that they want, you know,
10 100 percent Medicare, then what they do is
11 they set it up, their UCR, and they set
12 whatever percentage of UCR they're going to
13 pay and they'll just pay it that way as an
14 out-of-network. I'm exaggerating slightly --

15 MR. SCHWARTZER: Right.

16 MS. DICUS-JOHNSON: -- but the
17 point is --

18 MR. SCHWARTZER: We agree. The
19 problem is that the anesthesiologist, the
20 pathologist, the radiologist, the area docs
21 all have captive audiences and they're not
22 willing to negotiate. That is ultimately the
23 problem. I don't disagree with that. You do
24 the best you can to use the market forces,
25 but the reality is that the doctor knows, I

1 don't have to worry about it because the
2 patient is not going to choose me, the
3 hospital is going to choose me, and I can
4 charge whatever I want to charge. That is
5 ultimately the problem. And the best I think
6 that we can do, even as a group, is to make
7 the patient aware that that radiologist is
8 the one that's contracted at this hospital,
9 and the patient needs to be able to find out
10 from the carrier whether that's in-network or
11 out-of-network and then have the ability to
12 say, Mr. Hospital, I think that's a bad idea
13 that you're contracting because this
14 radiologist is a part of my network, or they
15 can put some market pressures on.

16 But right now without the knowledge that
17 the radiologist at this hospital -- it's a
18 two-way street. Communication has to come
19 from the payers and it has to come from the
20 providers. And we do provide it at the payer
21 level. We provide that information at the
22 payer level, saying radiology is not covered
23 at Elmbrook Memorial, period, in your
24 network. But now the patient has to be able
25 to get information back from the other side,

1 from the provider side, reminding them,
2 here's our radiologist at Elmbrook Memorial.

3 MS. LEITCH: So when somebody
4 purchases a product, it says this hospital
5 does not have these services covered?

6 MR. SCHWARTZER: Typically, yes.

7 MS. LEITCH: So when somebody is
8 deciding to purchase that product or not,
9 they contract with this --

10 MR. SCHWARTZER: The networks in
11 our association do that. They have a list
12 of -- if it's Elmbrook Memorial, sometimes
13 they use icons, sometimes they use names, and
14 say Elmbrook Memorial, anesthesiologist
15 covered, ER is covered, but there's no icon
16 for radiology, meaning radiology is not
17 there.

18 MS. LEITCH: So they know what
19 product it is that they are purchasing and
20 that there is someplace in that product that
21 they can go to a hospital and have all of
22 that stuff, they would know that when
23 purchasing the product?

24 MR. SCHWARTZER: Right. Looking at
25 a directory that's current at the time of

1 printing, which changes as we know.

2 MS. DICUS-JOHNSON: Who do you
3 represent? Who are the plans that you
4 represent?

5 MR. SCHWARTZER: Golden Rule, the
6 networks in Beech Street, Golden Rule Health
7 US is another network. I'm trying to think
8 of --

9 MS. DICUS-JOHNSON: That's fine.

10 MS. LEITCH: Is that based on OCI
11 regulations that they provide that
12 information or do they just do it because
13 it's the right thing to do?

14 MR. SCHWARTZER: They just do it to
15 try to inform the consumer. I mean, I used
16 to work in a network, and I did many
17 employment enrollment meetings and you try to
18 let them know right upfront about the
19 ancillary services and that it's a problem
20 and that you need to be cautious. Most
21 network directories have a statement that
22 says be cautious about ancillary providers.
23 That's now part of it.

24 MR. GOMEZ: Okay. Well, we
25 resolved that so -- this is what we're going

1 to do, on the easier issues there were some
2 comments relative to the emergency room rule
3 that people shared and discussed. To the
4 extent that there's anything written that
5 people want to provide on that, please ship
6 it off to Eileen, maybe within ten days, ten
7 business days. And then what I think we'll
8 do then is try to incorporate some of
9 whatever new comments there are on the
10 emergency room rule and circulate a draft.

11 As I said earlier, I don't foresee much
12 real disagreement as to where there may be
13 some -- there may be some tweaks on what's
14 out there now, but I think we'll be able to
15 resolve that issue pretty quickly and
16 hopefully the draft that will circulate will
17 incorporate all of your concerns.

18 As for this other topic, there's a list
19 of things that I think Fred had suggested we
20 get. What was that list, Fred? The list
21 included the disclosures that may currently
22 be provided by the hospital systems relative
23 to what patients may be told about ancillary
24 services, if there are any. There was a
25 Gundersen that provides --

1 MS. CURRAN: It provides just a
2 general disclosure --

3 MR. GOMEZ: Your general
4 disclosure.

5 MS. CURRAN: -- about financial
6 liability.

7 MR. GOMEZ: Right. And maybe some
8 general description as to how that is sorted,
9 when it's sorted out with your -- is there
10 any way you can give us an idea of how that
11 works?

12 MS. LEITCH: Sure. In ten days,
13 right?

14 MR. GOMEZ: You obviously want to
15 share something?

16 MS. DICUS-JOHNSON: No, I was
17 just -- I'm going to provide something.

18 MR. GOMEZ: Okay. And Coreen is
19 going to provide us -- what are you going to
20 provide us?

21 MS. DICUS-JOHNSON: We're going to
22 give you the disclosure in terms of the
23 financial liability.

24 MR. GOMEZ: Okay. And J.P. is not
25 off the hook because you're going to draft

1 something too.

2 MR. WIESKE: What's my due date?

3 MR. GOMEZ: Can't you do ten days?

4 MR. WIESKE: I can probably do ten
5 days.

6 MR. GOMEZ: We'll get all this
7 stuff. We'll do something with it. We'll
8 draft some more stuff. We'll circulate or
9 make available everyone's comments to each
10 other, and on May 8th was the next date of
11 potentially coming back --

12 MS. MALLOW: No, May 8th is the
13 ten-day comment period.

14 MR. GOMEZ: May 8th is the ten-day
15 comment period. Okay. And then we'll figure
16 out another date to torture ourselves on this
17 issue. Is the Agency going to pick a date
18 now, a tentative date? We'll figure out
19 something Wednesday afternoon in the next six
20 weeks.

21 MS. MALLOW: The 10th or 17th of
22 May, how does that sound for people?

23 MR. GOMEZ: That might be soon. We
24 need more time than that.

25 MS. MALLOW: The 17th or 24th of

1 May at 2:00?

2 MR. GOMEZ: I may not be around.

3 We'll sort that out. We'll figure out a
4 date. Wednesday afternoons are good. Thanks
5 a lot.

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 (Adjourning at 4:31 p.m.)

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1 STATE OF WISCONSIN)
) ss.
2 COUNTY OF DANE)

3

4 I, REBECCA FARRIS, a Notary Public in and for the
5 State of Wisconsin, do hereby certify that the foregoing
6 hearing was taken in shorthand by me, a competent court
7 reporter and disinterested person, approved by all
8 parties in interest and thereafter converted to
9 typewriting using computer-aided transcription; and that
10 same is a true and correct transcript.

11 Dated May 16th, 2006.

12

13 Rebecca Farris
14 Notary Public, State of Wisconsin

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